DOCUMENT RESUME

ED 304 228 PS 017 830

AUTHOR Molnar, Janice; And Others
TITLE Home Is Where the Heart Is: The Crisis of Homeless Children and Families in New York City. A Report to the Edna McConnell Clark Foundation.
INSTITUTION Bank Street Coll. of Education, New York, N.Y.
SPONS AGENCY Edna McConnell Clark Foundation, New York, N.Y.
PUB DATE Mar 88
NOTE 141p.
AVAILABLE FROM Bank Street College of Education, 610 West 112th Street, New York, NY 10025 ($14.45, plus $2.40 handling).
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS *Childhood Needs; *Delivery Systems; Education; *Family Problems; Futures (of Society); *Health; *Homeless People; *Nutrition; Preschool Children; Welfare Services
IDENTIFIERS *New York (New York); Transitional Shelter System

ABSTRACT

This report on homeless children between infancy and 5 years of age highlights issues facing the 11,000 homeless children and their families living in emergency temporary housing in New York City. The rising incidence of homelessness among families is considered in national and local contexts. There follows an overview of the transitional shelter system in New York City and the many agencies serving homeless children and their families. Subsequent sections profile what is known about the health, nutrition, education, and child and family welfare of homeless chilndre. This discussion is followed by developmental descriptions of young children observed during a 6-month period at the American Red Cross Emergency Family Center. Concluding sections highlight key issues that need to be addressed if homeless children and their families are to have a better future. Appendices provide related material, such as a summary of a research and policy roundtable discussion on homeless children and families that focused on: (1) what is known about the impact of homelessness on children and families; (2) strategies most effective for supporting at-risk families; (3) most effective ways of measuring child development and family functioning; and (4) suggestions for future agendas and advocacy efforts. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED304228

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it

☒ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

Home Is Where the Heart Is:

The Crisis of Homeless Children and Families in New York City

A Report to the
Edna McConnell Clark Foundation

by
Janice Molnar, Ph.D.

With the Assistance of
Tovah Klein

Special Advisor
Jane Knitzer, Ed.D.

Research Consultant
Blanca Ortiz-Torres

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Janice
Molnar

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Bank Street College of Education
March, 1988

PS 017330

HOME IS WHERE THE HEART IS:

THE CRISIS OF HOMELESS CHILDREN AND FAMILIES IN NEW YORK CITY

A Report to the
Edna McConnell Clark Foundation

by
Janice Molnar, Ph.D.

With the Assistance of
Tovah Klein

Special Advisor
Jane Knitzer, Ed.D.

Research Consultant
Blanca Ortiz-Torres

Bank Street College of Education

March, 1988

LOOKING

I want out.
A home to call my own.
Where can I go?
Who can help me?
What must I do?
When will this stopover
in a sort of hell ever end?

I've been here.
I've been there.
Only to be told
"SORRY, TOO LATE.
Take this address and go there.
I wish you luck."

Luck. Ha!
If that's what it takes,
then I am doomed to live a lifeless life,
My children and I in homeless homes,
never knowing for how long.

Laura Lee Nash

From: *The Women of the Regent Hotel*, a collection of poetry and photography produced by participants in a poetry workshop run by the Child Development Center of the Jewish Board of Family & Children's Services, Inc.

ACKNOWLEDGEMENTS

We are grateful to the Edna McConnell Clark Foundation for its support of our beginning efforts in understanding the context of homeless families and their children in New York City. We drew on the knowledge and expertise of many individuals in the city, including agency staff, program providers, advocates, parents, and children. In particular, we appreciated the insights that program providers shared with us; we were inspired by their commitment to improving conditions for homeless children and their families. Principles of confidentiality prevent us from acknowledging by name all those who contributed to this document. But we thank you.

We also wish to thank the "behind-the-scenes" people whose support of our work helped to move it forward: Peter Derrick and Anne Mitchell for their editorial assistance and all-around support, Annelie Hartmann and Naomi Hupert for their patient and cheerful help with producing this report, Joan Auclair for designing the cover, and most especially Liz Westfall---who went the extra mile in putting it all together---for her endless energy and commitment to the project.

TABLE OF CONTENTS

Acknowledgements iii

List of Tables vii

Executive Summary ix

Introduction to the Report 1
- Who's In Charge? 2
- Methodology 3
- Overview of the Report 6

Introduction to the Children 8

The National Context 10

Homeless in New York City: The Local Context 16
- It's a Nice Place to Visit But 16
- Who Are New York City's Families? 19
- Why Are They Homeless? 20
- How Long Are They Homeless? 21

Sorting Out The Maze: Serving Homeless Families 24
- The Process 24
- Types of Shelters 25
- Where Do Homeless Families Come From and Where Do They Go To? 29
- The Cost of Shelter 31
- Agencies Serving Homeless Children and Their Families 33

Health Care for Homeless Children 36
- Infants At-Risk 37
- Health Problems in Homeless Children 41
- Health Care Providers 43
- Special Initiatives 45

Nutrition 48
- Supplemental Food Programs 49
- Hungry Children 53

Educational Programs for Children 56
- School-Aged Children 56
- Preschool-Aged Children 59

Child and Family Welfare 70
- The Mental Health Status of Homeless Families 70
- Access to and Eligibility for Services 71

A Special Look at Preschoolers 75
- Observational Data 76

Children's Strengths 79
Assessment Issues 81
Impact of Inadequate Family Supports on Child Development 82
Parting Snapshot 86

Issues and Challenges for the Future 88
The Setting: Its Influences on Parents and Children 88
Service Delivery Challenges 92
Issues for the Future 100

References 108

Appendices 113

LIST OF TABLES

Table 1

Families in Emergency Shelter in New York City 27

Table 2

Location of Emergency Shelter in Relation to Families' Borough of Last Residence 30

Table 3

Average Costs of Sheltering Homeless Families in New York City..32

Table 4

Early Childhood Programs for Homeless Children..62

EXECUTIVE SUMMARY

This report is the product of a six-month effort supported by the Edna McConnell Clark Foundation. It highlights some of the issues facing the 11,000 homeless children and their families living in emergency temporary housing in New York City. Throughout the report our prime focus is on the youngest homeless children ages birth to 5. This emphasis results from our belief that there is a need for immediate action to halt the potentially damaging effects of homelessness on young children. Although the most basic problem is inadequate housing, there is no doubt that this will not be solved soon. As solutions and strategies are debated, young children are living their lives. They are not waiting. Something must be done *now* to assure their well-being.

The Context of Homelessness: National and Local Perspectives

Homelessness in New York City is not a sudden crisis but is a predictable outcome of some very intentional federal policies, aggravated by unaccommodating local conditions. Nationwide, there may be as many as 3 million homeless people, one-third of whom are families with children. Across the country, and no less true in New York City, families are the largest growing segment of the homeless population. National trends contributing to the exploding numbers of homeless families include: the movement of the federal government out of the low-income housing market; decreased federal support of social programs serving the poor; a growing service and information-based economy that is squeezing out the least educated segment of the labor pool; and changing demographic trends.

Locally, the context from which New York City's homeless families come is an extraordinarily tight housing market which has been particularly hard hit by federal housing cuts. At the lowest income levels, there is a citywide vacancy rate of only 1%, and a wait for public housing up to 18 years long. As with the national picture, it is more than housing that is the problem. It is also family economics. Almost one-third of New York City families with children live below the poverty level, making them least able to compete in a very competitive market.

Homeless Families in New York City

On Thanksgiving Day, 1987 there were 5,116 homeless families in emergency shelters in New York City. This included 6,737 adults and 10,945 children, half of whom were under age 5. Families had an average of two to three children. Ninety-five percent of the families were Black or Hispanic; 86% were headed by women; 11% had household heads under age 21. Prior to applying for emergency shelter, half of the families had shared living arrangements with relatives or friends. By the time they sought the City's help, they had exhausted all personal and family resources.

Systems and Services for Homeless Children and Their Families in Transitional Shelters

Families are homeless for an average of 13 months before being re-located to permanent housing. The majority of families (69%) are housed in commercial hotels, at costs averaging $1,800/month for a family of four. There are no State-mandated services for families in the hotels, although City-employed caseworkers attempt to serve 60 families each. One in 10 families is sheltered in barracks-type congregate facilities, where the maximum stay is not supposed to exceed 21 days. Costs for sheltering a family of four here is $1,989/month. Just over 20% of homeless families are sheltered in facilities run by not-for-profit organizations which, while less expensive ($1,041/month for a family of 4), are more service intensive. They are mandated by State regulation to provide child- and family-focused services, such as permanent housing preparation services, information and referral services, access to health care, and child care services.

Agencies

A multitude of agencies within four City departments---the Human Resources Administration, the Department of Housing, Preservation and Development, the

Department of Health, and the Board of Education---have responsibility for one phase or another of a homeless family's daily life. The agencies and some of their services are briefly described. Among their most striking features are (1) the lack of coordination of services, and (2) the non-integration of services to adults and children.

Services

We were concerned with those issues of most importance for the optimal development of the young child---health care, nutrition, early childhood education, child and family welfare. Thus, to the extent that data would allow, we profiled the status of homeless children in these areas and described some of the programs designed to serve them.

During the course of our investigation, we visited 15 programs that serve homeless children. Because of our special focus on children's overall developmental profile, we supplemented our program visits with informal observations on a weekly basis over a six-month period at one on-site day care program. We also sought the input of experts from around the country who have worked with homeless or other at-risk children.

The resulting synthesis painted a sobering picture of the status of young homeless children in New York City.

Health Care. Homeless children are sick at rates many times higher than the average child and often their illnesses go untreated until they become serious, even life threatening. More than half of all pregnant women living in welfare hotels have minimal or no prenatal health care, twice the statewide average. One out of six of the infants born to mothers living in welfare hotels are low-birthweight. Gastroenteritis is one of the most common reasons for homeless infants being admitted to hospitals, the condition often resulting from the ingestion of harmful bacteria from stale infant formula and unsterilized bottles. Close living quarters, poor nutrition, lack of medical care, and non-immunization (75% in a cross-age sample in the Hotel Martinique) create breeding grounds for what are usually easily treatable and curable diseases, e.g., anemia, lead poisoning, lice, asthma, diarrhea, pneumonia, ear infections.

Several new initiatives in providing health care to homeless children are described.

Nutrition. Homeless children are hungry. We observed children who tantrumed for fear of not being fed; children who, when they *were* fed, ate two or three helpings. Food programs serving homeless children are insufficient, benefits even less so. Almost half of family members in New York City shelters who are eligible for food stamps do not receive them. When they get them, homeless children receive $2.13 a day for a restaurant allowance, plus $1.58 a day in food stamps. Statewide, the federally-funded Special Supplemental Food Program for Women, Infants and Children (WIC) does not even serve half of those eligible. The figures for homeless families are not known, but only one shelter has a WIC office on site. Malnutrition is a possible consequence of these inadequacies.

Educational Programs. Of the 6,000 school-aged homeless children, maybe only half attend school. For the 5,500 children birth to 5 years of age, there are 850 early childhood education slots, the majority for 3- to 5-year-olds. However, illness, fear, lack of motivation---all contribute to low attendance, even for programs located on site. Among the preschoolers we saw regularly, the following behaviors were observed: short attention spans/weak impulse control, withdrawal, aggression, speech delays, sleep disorders, "regressive"/toddler-like behaviors, and inappropriate social interactions with adults and peers. The consequences of maternal depression can be particularly severe, so can inadequate family supports. Abbreviated case studies and behavioral vignettes illustrate these points. Their implications are considered from the perspective of services that should be exploited for this population; e.g., those required by the federal mandate to serve developmentally disabled preschoolers (P.L. 99-457), or by New York State's Child Welfare Reform Act, which mandates the provision of preventive services to children at risk of imminent removal to foster care.

Issues and Challenges for the Future

The shelter system, as it has evolved in New York City, is the result of a lack of leadership, and a haphazard approach to program design and service delivery. Rather than exploiting the service opportunities to intervene with a highly at-risk population, the system is designed to discourage people from seeking access to it. The final section highlights some of the key challenges to effective service delivery in New York City, e.g., the lack of leadership at all levels of government, fragmented and inflexible services, the split of services to parents and children, and the lack of continuity in service delivery. It concludes with a summary of issues that must be seriously addressed if homeless children and their families are to be effectively served. Among the issues discussed:

- Citywide leadership around the provision of services to children
- Enforcement of existing regulations
- Development of an individualized family-based service plan
- Comprehensive needs assessment
- Flexibility of services
- Case management
- Continuity
- Proactive support for parents.

INTRODUCTION TO THE REPORT

This report highlights some of the issues facing homeless children and their families in New York City. In so doing, it brings together the results of a half-year's work supported by the Edna McConnell Clark Foundation. In our proposal to the Foundation, we laid out three questions that we hoped to answer during the course of the grant period:

(1) What kinds of assistance do homeless children and families now receive in New York City and what impact do they have on how children develop and families cope?

(2) Based on our knowledge of the best strategies to enhance children's development and enhance coping skills among seriously stressed, marginally functioning families, what kinds of interventions make the most sense for homeless families?

(3) Which City policies and practices need to be modified to focus more effectively on developmental/mental health and family functioning needs?

We have only begun to answer these questions. When we started this project, we knew little about the context in which homelessness exists in New York City. What we knew about the systems and agencies and programs serving the homeless, or about the pathos of individual lives caught up in the system's web, we knew mostly from news accounts---and they didn't tell us much about the children.

In asking these questions, we wanted to pay particular attention to preschoolers. We felt this was important for several reasons. First, it is well established that in their earliest years, children are more susceptible to permanent damage, as well as to the benefits of intensive intervention, than at almost any other time of their lives. We recognize that throughout the life span, there is always potential for either breakdown or renewal, but prevention is well known to be more effective than repair. For children as vulnerable as the homeless, the arguments for identifying potentially irreversible damage early and mounting intensive interventions seems especially compelling.

Second, the early childhood period offers the most potential for supporting the whole family as an integrated unit. Parents of young children, for example, are often more receptive to learning new parenting skills than families of older children. Unfortunately, one of the main findings of this report is that families are not treated as a unit. More often than not, the social service delivery system operates *against* family preservation. Fragmentation is the name of the game.

Third, children ages 5 and under comprise the largest single age cohort within New York City's homeless population. As a whole, there are more homeless children than homeless adults, 11,000 for the former, 10,200 for the latter. Moreover, of the 11,000 homeless children birth to age 18 living in emergency shelter in New York, 5,500 are below the age of 5.

The emphasis on preschoolers sets off this investigation from other reports on homelessness in New York. This stress on the most vulnerable age cohort results from our belief that there is a need for immediate action to halt the potentially disastrous long-term effects of homelessness on young children. Other studies, in contrast, have focused primarily on the need to provide homes for these children and their families. While the need for housing cannot and should not be minimized, action must be taken to support the proper development of young children in transitional housing environments. A second distinguishing feature of this report is that it does not take a single agency or topical perspective (e.g., health, education) as its point of departure. Because the young child is the lens through which we looked, we attempted to take the broad view of programs and services to homeless children and their families.

Who's in Charge?

As we began to explore programs and services specifically for homeless families, we were struck anew by two all too consistent facts of City programs and practices: (1) the lack of coordination of services, and (2) the non-integration of services to adults and children. As we tried to piece together services to homeless families and children and relate them to the level of need in the population, in all too many instances we didn't know whether we were unable to find answers to our questions because the answers are not known, or because we just didn't contact the right office. It took, for example, 14 phone calls to the City's Department of Health to discover that there is no central bank of health data on homeless children. Although there are numerous health providers serving homeless families, no one is coordinating their efforts. No one knows level of need; neither does anyone know to what extent the existing need is being met.

This situation is not unique to health services; it is true for social services and early childhood education, for food services and child welfare. How many developmentally delayed homeless children have access to special education as mandated under P.L. 99-457 (the extension of the Education for All Handicapped Children Act to preschoolers)? No one knows. More importantly, how many children *should* have access to mandated special education services? Again, no one knows. How many homeless children have been placed in foster care essentially because they are homeless? What kinds of efforts are being made to reunite parents and children? What is the incidence of severe depression among homeless parents? What is the incidence of serious drug use? How many families make use of what clusters of services? How many remain unserved? The list of important gaps in what we know about services to homeless families and children is a long one.

Given all this, we determined that it would be useful to synthesize what is known about services from the perspective of children. Since so little consistent information is available, pulling things together was a necessary first step, both for ourselves as well as for other groups and individuals concerned with the homeless in New York. Before anyone can say where we should be going, we must know with some precision where we are now.

Methodology

Our underlying goal was to understand the context of homeless families and children in New York City, and the potential impact of programs and policies on children's development. In order to do this, we engaged in the following activities:

(1) *Program Review.* During the course of our work, we visited 15 programs serving homeless children. These programs were not randomly selected. Rather, they were chosen because they were identified as having some capacity to compensate for, or enhance, appropriate developmental growth in children. Thus, they had some or all of the following components:

- Developmental day care (from drop-in care to half-day programs to all-day programs)
- Medical care (usually through linkages with local health providers)
- Social services (ranging from referral and informal counseling, to intensive group work and self-help advocacy of parents)
- Re-housing supports (as provided by on-site staff)

Nine of the programs we visited were part of, or co-located with, on-site transitional shelters, including six non-profit programs and three publicly-supported hotels. The six off-site programs all had among their services an early childhood program. They included one Head Start program, two Agency for Child Development (ACD) programs, two privately-funded all-day day care programs, and one privately-funded drop-in day care program. (See Appendix A for a list of all programs visited.)

Our visits had a dual purpose. Not only were we trying to learn about the particular program and its offerings, but we were also trying to gain multiple perspectives on issues related to homelessness in general, and the impact on families and children in particular. Therefore, we talked to social workers, housing specialists, and day care teachers, as well as program directors. Our conversations were guided by a standard interview protocol which tapped the following areas: program background and history, characteristics of the client population, organizational structure, program components, staffing, funding, general issues and challenges (including barriers to program implementation), and recommendations for policy change. (See Appendix B for a copy of the standard interview format).

(2) *Child-Focused Observations.* Since a major emphasis of our work is the status of homeless preschool children, we conducted informal child observations on a weekly basis at an on-site day care program, using a modified participant observation strategy. One of our project staff spent a half-day every week for six months at the American Red Cross' Emergency Family Center volunteering in the day care center, and informally interacting with the children. (See Appendix C for a schedule of those visits). Over time, it was possible to contruct developmental profiles of some of the children in attendance, based on their week-by-week interactions with teachers, parents, peers, and materials.

As elaborated in a later section, these child profiles enabled us to speculate on the most effective strategies for supporting homeless families. The observations served a second purpose as well. They provided us with data for considering alternative methods of assessing child growth and development, which we hope to expand in future work.

(3) *Research Roundtable.* In November 1987, we convened a group of experts from New York City and around the country who are experienced with the problems of homeless families and children or with other at-risk populations. (See Appendix D for a list of participants.) The broad purpose of this roundtable was to consider, from both a program and policy perspective, in what ways homeless children and their families can best be supported in their move toward self-sufficiency. The agenda was guided by the following four questions:

(1) What do we know about the impact of homelessness on young children and their families?

(2) How can we best work with seriously at-risk and dysfunctional families? What are the critical ingredients of successful program interventions?

(3) What don't we know that we should know in order to make sound policy recommendations?

(4) What are the research challenges encountered in working with vulnerable populations? For example, what are effective assessment strategies for evaluating child development and family functioning? How would existing methodologies need to be modified for use with a homeless population?

In order to establish a common frame of reference, each participant submitted relevant papers, research findings, and program descriptions, summaries of which we prepared and distributed to the whole group in advance of the meeting. The roundtable provided a forum for identification and discussion of some key issues, a summary of which can be found in Appendix D. Based on participants' desire to discuss some issues in more depth (particularly ones having to do with appropriate measurements of child development and family functioning), we will be re-convening the group in the late spring with support from the Foundation for Child Development.

(4) *Status Reports of Basic Needs and Services.* Taking the issues of most importance to the optimal development of the young child---health care, nutrition, early childhood education, child and family welfare---we profiled (to the extent that available data would allow) the status of New York City's youngest homeless victims. We also reviewed programs in these areas that are meant to serve the needs of the children and their families. Our information came from the following sources: interviews/contacts with public officials, agency staff, program providers, and advocacy groups; and review and synthesis of existing reports and other documents. (See Appendix E for a list of programs and agencies we contacted.) Although the information we gathered has many gaps, it nonetheless paints a sobering picture of what happens to young children when the bottom falls out and there is no "safety net" to catch them.

Overview of the Report

This report begins with an introduction to homeless children in New York City. The rising incidence of homelessness among families is then placed in both national and local contexts. Following this is an overview of the transitional shelter system in New York and the many agencies serving homeless children and their families. The next sections profile what we know about homeless children in those areas that are important to the optimal growth of all children: health, nutrition, education, and child and family welfare. This is followed by a developmental snapshot of the young children we observed over six month's time at the American Red Cross' Emergency Family Center. Our concluding sections highlight some of the key issues that need to be addressed in order for homeless children and their families to have a better future.

INTRODUCTION TO THE CHILDREN

- There are 10,945 homeless children in New York City.
- Half of them are under age 5.
- 10% are under age 1.

Shelter Arrangements

- 10% of New York City's homeless children are sheltered in barracks-style, congregate facilities.
- 21% are in shelters run by not-for-profit organizations.
- 69% are in welfare hotels.

Health and Nutritional Status

- One in six of the infants born to mothers in New York City welfare hotels are low-birthweight.
- The infant mortality rate in welfare hotels is 24.9 per 1,000 newborns, compared to 10.6 citywide.
- More than half of all pregnant women in welfare hotels in 1985 received minimal or no prenatal care.
- Three-fourths of children living at the Martinique Hotel are under- or non-immunized.
- Homeless children receive $2.13 a day (per person) for a restaurant allowance, plus $1.58 a day in food stamps.

Access to Services

- Forty-nine percent of family members in New York City shelters who are eligible for food stamps do not receive them.
- Only one shelter has an on-site WIC office.
- Only 50% of homeless children ages 6-17 attend school.
- There are some 6,000 school-age children. By Labor Day, 1987, only 583 had been registered for school.
- There are 850 early childhood education slots for the 5,500 children birth to 5 years of age; the majority of these are for 3- to 5-year-olds.

These are our children---easily broken, not easily fixed.

THE NATIONAL CONTEXT

Families with children are the largest growing segment of the homeless population.

We've heard them many times now, but the numbers continue to haunt. Nationwide, it's estimated that there are anywhere from 250,000 to 3,000,000 homeless people, one-third of whom are children. Families are, in fact, the largest growing segment of the homeless population (U.S. Conference of Mayors, 1987).

With unrelenting predictability, the numbers grow larger instead of smaller. Although our public officials appear stunned and amazed---and hence unprepared---what our nation is experiencing is not a sudden crisis, but a predictable outcome of some very intentional federal policies, aggravated by unaccommodating local economic conditions. Several jointly occurring trends have been key contributors to the exploding numbers of homeless families in New York City and across the country: the movement of the federal government out of the low-income housing market; decreased federal support of social programs serving the poor; a growing service and information-based economy that is squeezing out the least educated segment of the labor pool; and changing demographic trends.

The bottom-line need of the homeless and of the countless hundreds of thousands of others who live doubled or tripled up with other households is the need for adequate and affordable housing. For 50 years, beginning with the federal Housing Act of 1937, the federal government, with the participation of state and local authorities, shouldered fundamental responsibility for providing "...decent, safe and sanitary dwellings..." for the nation's low-income people. With the current administration, that policy has come to an end. During the

Reagan presidency, support for subsidized and public housing programs has gone from $32 billion to $7.5 billion--a reduction of over 75%---while government subsidies in the form of mortgage tax exemptions for middle- and upper-income homeowners have grown to $42 billion (National Coalition for the Homeless, 1987).

During the Reagan presidency, support for subsidized and public housing programs has gone from $32 billion to $7.5 billion.

At the same time as federal support was declining, existing low-income housing was aging. Some of it has now gone the way of gentrification and urban renewal, and some has deteriorated beyond the point of liveability. Each year, 2.5 million people lose their homes due to redevelopment, condominium conversion, or abandonment (Children's Defense Fund, 1987). This can only be expected to get worse as federal contracts for subsidized housing expire. The reason is that many housing projects that were built in the 1970s with federal subsidies are privately owned. Rental over a 20-year period to low- or moderate-income tenants was the condition for subsidy. But after the contracts expire, as they will for as many as 900,000 units by 1995, owners can refinance and rent to anybody, without restriction (Smith, 1988).

There were 8 million low-income renters in the market for 4.2 million low to moderately priced units in 1985.

The result is increased competition for an ever-shrinking supply of low-income housing stock. According to the Low Income Housing Information Service, there were 8 million low-income renters in the market for 4.2 million low to moderately priced units in 1985. As it is, six million households nationwide pay at least half of their income for rent; 4.7 million pay 60% or more (Hartmann, 1986). Where does that leave the poor? Those least able to maintain the competitive edge (the elderly, the disabled, those most vulnerable to economic stress) literally move out of the market.

A second contributing factor to the growing number of homeless families is the national growth in poverty. This has been a function both of rising unemployment or underemployment, and cutbacks in federal entitlement programs. One recent study by the Center on Budget and Policy Priorities calculated a 35% increase in the number of poor families with children between 1979 and 1986. Since 1981, eligibility and payment standards for AFDC have been tightened three times, resulting in a loss of over $3.6 billion in AFDC payments nationwide (National Coalition for the Homeless, 1987). Non-cash benefits, like food stamps, have also been cut. Since 1982, $6.8 billion has been cut from the Food Stamp program, pushing one million recipients off the program and reducing benefits for 20 million people, most of whom are children (National Coalition for the Homeless, 1987).

Since 1981, eligibility and payment standards for AFDC have been tightened three times.

Since 1982, $6.8 billion has been cut from the Food Stamp program.

The working poor have been hit particularly hard, as their entry into the ranks of the homeless attests---according to some estimates reaching as high as 20% (National Coalition for the Homeless, 1987). National unemployment figures of 5.8%, moreover, do not reflect those persons working at dead-end, minimum wage "McJobs." A person working a 40-hour week at a minimum wage job grosses only $536/month. The minimum wage has not been raised since 1981; the cost of living, however, has gone up 33.1% since then (National Coalition for the Homeless, 1987). Neither does the unemployment rate reflect the numbers of part-time workers who would rather be working full-time, or those who have exhausted their unemployment benefits, or the countless numbers of discouraged workers who have just stopped looking for work. The shift in our economy from producing goods to producing information is leaving behind the uneducated, the unskilled, and the inappropriately skilled.

Nationally, a child in a single-parent, female-headed family is at least five times more likely to be poor than a child in a two-parent family.

Lastly, the rapid increase in the numbers of households headed by women has contributed to a new "feminization" of poverty. Between 1970 and 1980, the number of children in single-parent households (most often headed by women) increased by over 44% from one in every eight children in 1970 to one in five in 1980 (Children's Defense Fund, 1982). America's poorest families are those headed by women. Nationally, a child in a single-parent, female-headed family is at least five times more likely to be poor than a child in a two-parent family (Children's Defense Fund, 1985). These many unsympathetic factors battering our nations's families have put them in an ever more precarious position.

The double grip of poverty and restricted housing options has fundamentally changed the demographic portrait of the homeless in America. It has shattered the myth that the homeless are bums (not even half of the homeless are single men, according to a recent U.S. Conference of Mayors' report) or shopping bag ladies (only 14% of the homeless are single women, the same document reports) or runaway youth (only 4% of the homeless are said to be unattached youth; this number, however is extremely difficult to estimate reliably). Moving accounts of individual family tragedies are increasingly finding their way into the popular press. Tales of hard luck and bad times are presented in wrenching detail. In November, 1987, a *New York* magazine reporter spent the night with a Black homeless mother and her four children in the Brooklyn Arms Hotel. In December, *Life* brought us a week in the life of a White Los Angeles couple and their two children, a third on the way. Even *Fortune* magazine has done a special report on homeless families. And who, have the reports told us, are the homeless? They are us.

They are former foster care children; they are former blue collar workers; they are former television newscasters. In a recent editorial, *Better Homes and Gardens* asks,

> "How can this be? What's happened to our country? Is this the America we want for ourselves and our families?" (February, 1988, p. 10)

In an analysis of the pathways to homelessness in a sample of 87 families in five Los Angeles County shelters, Kay Young McChesney (in press) identified four types of homeless families:

(1) Intact families where the primary breadwinner, usually a former blue-collar worker in a declining industry, is unemployed;

(2) Single mothers with children, who have recently left relationships with men on whom they were dependent for economic support;

(3) Long-term AFDC families; and

(4) Young mothers who have aged out of the foster-care/juvenile system, i.e., formerly homeless teenagers.

Two other groups that might be added to this taxonomy include:

(5) Young mothers who have previously lived with their families of origin and have never lived independently; and

(6) Latin American refugees whose numbers in some parts of the country are swelling.

Regardless of the specific pathway, homeless people are primarily characterized in terms of a past. Within a culture in which self is defined in terms of role and function, and in which future goals and aspirations are deemed so important, the homeless are a group in limbo.

The July, 1987 passage of the Stewart B. McKinney Urgent Relief for the Homeless Act (P.L. 100-77) appeared to be a signal that Congress was beginning to realize and respond to the enormity of the problem. The commitment has fallen short of the promise, however. Whereas Congress authorized $1.4 billion to be spent in Fiscal years '87 and '88, only half of that amount has been appropriated for both years (*New York Newsday*, January 27, 1988). We are a nation that extols family virtues. Yet, in a pinch, families are literally left out in the cold.

HOMELESS IN NEW YORK CITY: THE LOCAL CONTEXT

On Thanksgiving Day 1987, New York City sheltered 27,430 homeless people: 8,513 single men, 1,235 single women and 5,116 families including 6,737 adults and 10,945 children (City of New York Human Resources Administration [HRA], 1987).

That the number of homeless New Yorkers is stabilizing---or even dropping by a few hundred people from one month to the next is headline news ("Number of Homeless Far Below Shelter Forecasts," *New York Times* January 26, 1988). That it is stabilizing at around 27,000 people in the shelter system (not including those who choose not to enter the shelter system, or the over 100,000 low-income families that may be doubled up in the apartments of friends or relatives) seems almost parenthetical.

Over the course of a year, 11,800 different families pass through emergency shelters in New York City.

In 1980, 15,000 federally subsidized low-income units were constructed in New York City, compared to 1,000 in 1986.

Even though the number of homeless people in New York may have reached a plateau, there is no doubt that the number of homeless families in New York has grown rapidly in recent years. HRA (1988) reports a growth in the number of families sheltered by the City from 800 in 1978, to 2,500 at the end of 1983, to over 5,000 in December 1987. Over the course of a year, 11,800 different families pass through emergency shelters in New York City.

It's A Nice Place To Visit But....

The context from which New York City's homeless families come is an extraordinarily tight housing market which has been particularly hard hit by federal housing cuts. In 1980, 15,000 federally subsidized low-income units were constructed in New York City, compared to 1,000 in 1986

(*New York Times*, January 21, 1987). Between 1978 and 1984, the period during which New York City's homeless families tripled in number:

- Median rent levels in the city rose from $210 to $330 monthly;
- The number of housing units renting for below $300/month went from 1.7 million units to less than one million. This amounted to a loss of over a third of the city's low-income housing stock;
- Abandonment alone produced a loss of 150,000 units (Bach & Steinhagen, 1987).

One-third of all New Yorkers spend more than 40% of their income on housing.

The end result is a vacancy rate of 1% at the lowest income levels (Bach & Steinhagen, 1987). Finding affordable, quality housing in New York is not easy at any income level given the citywide vacancy rate of a mere 2%. One-third of all New Yorkers spend more than 40% of their income on housing (B. Gorrie, presentation before the American Planning Association, April 26, 1987). However, renters with the smallest incomes are subject to the strongest pressures for displacement as landlords seek to meet the housing demands of the economically more well-to-do. This leaves the poorest households with the most rapidly deteriorating housing stock (see "New York City, The Landlord: A Decade of Decay," *New York Times*, February 8, 1988) and in many cases, with nothing at all, as more and more families double, triple, and even quadruple together in a single housing unit. In a city where the wait for public housing can be 18 years long (Dumpson & Dinkins, 1987), a particularly sobering statistic is that of New York's poorest renters in 1980, 20% did not have a place of their own by 1987 (Bach & Steinhagen, 1987).

The wait for public housing can be 18 years long...Of New York's poorest renters in 1980, 20% did not have a place of their own by 1987.

In an effort to alleviate one of the nation's most incredible housing crises, Mayor Edward I. Koch has put forth a $4.2 billion plan, which calls for the construction, preservation, and rehabilitation of 252,000 apartments for low- and medium-income tenants. While this is certainly a strong step in the right direction, a coalition of housing advocates has charged that the plan is discriminatory because it provides for only 24% of the units to go to families with annual incomes below $15,000 (*Daily News*, January 13, 1988). Regardless of distribution, however, Koch's plan is still insufficient. In a report prepared for the Commission on the Year 2000, it was estimated that by the year 2000, New York City is likely to need 372,000 more housing units than it will have (Felstein & Stegman, 1987).

It's more than housing that's a problem. It's also family economics.

As with the national picture, however, it is more than housing that is a problem. It is also family economics. A recent study by the Community Service Society of New York (Rosenberg, 1987) calculated a rise in the city's population of poor people (i.e., people living below the federal poverty level, or $10,609 for a family of four in 1984) from 1.4 million in 1979 to 1.7 million in 1984. This represents 23.5% of the city's total population.

Almost one-third of New York City families with children were living below the poverty level in 1984.

For families, the picture is worse. Almost one-third (31%) of New York City families with children were living below the poverty level in 1984. Among female-headed households, the poverty rate was double that for families as a whole---nearly two-thirds of households headed by women were poor. The *New York Times* (April 2, 1987) presented the household budget for one low-income family living in Far Rockaway, Queens. Barbara Jiggett, who was not employed, received a $270 shelter allowance, $266 in welfare payments, $172 in food stamps, and $50 in child support each month to support herself and three children (ages 4, 7, and 8) and pay a rent of $381. After rent, this family was left with $12.57 a day to pay for everything else.

Even the newly increased state shelter allowance (which would give this family an extra $42 per month) is not enough. This family lacks the economic resources to withstand any major crisis. If Ms. Jiggett is ever forced to move, what then?

Who are New York City's Homeless Families?

Data compiled by HRA, the public agency with responsibility for administering the shelter program in New York City, provides probably the most reliable picture of homeless families. Interviews of 77 families seeking shelter at selected Income Maintenance Centers and Emergency Assistance Units in December 1985, created the following profile of homeless families in New York:

- 86% of the families were headed by women; their average age was 27;
- 11.3% of the families were headed by parents under age 21;
- Families had an average of 2.3 children, with an average age of 6. Half of the children were below the age of 5; 10% were less than 1 year;
- 95% of the families were Black or Hispanic;
- 83% were recipients of Public Assistance; 73% used food stamps;
- 18% of the families reported that they were unable to keep all members of the family together during their period of homelessness;
- Only 8% had resided in New York City for one year or less (HRA, October 1986b).

A second survey of families at the Forbell Street Shelter and the Hotel Martinique (59 and 76 families, respectively) added the following information:

- Up to one-third of the household heads had graduated from high school;

- about one-half of the household heads reported that they had held a full-time job at some point in their lives (HRA, October 1986a).

The resulting portrait is that of a young, unskilled, and uneducated group of families who have exhausted, at least temporarily, their network of social resources.

The resulting portrait is that of a young, unskilled, and uneducated group of families who have exhausted, at least temporarily, their network of social resources.

According to the HRA (October 1986a), however, this profile is not vastly different from that of the public assistance population as a whole. One primary difference seems to be that homeless families are significantly more likely to have experienced multiple housing moves and multiple administrative (i.e., non-financial) closings of their welfare cases in a 12-month period. In addition, they tend to be younger heads of households (age 27 vs. 32), have younger children (64% vs. 54% have children under age 5), and larger families (3.5 vs. 3.1 members). Otherwise, homeless families have characteristics similar to the rest of the public assistance population. They have not experienced more long-term welfare dependency than other public assistance recipients. They do not pay rent any more in excess of the shelter allowance than other low-income renters (two-thirds of all public assistance recipients in private housing in New York City pay rent at or above the shelter allowance [HRA, 1988]); and they are from the same areas of New York (the most deteriorated neighborhoods of the city).

Why Are They Homeless?

For many families, by the time they request emergency shelter they have exhausted all personal and family resources. HRA data indicate that half of homeless families have come from doubled-up situations (HRA, October 1986b).

Housing-related incidents are the precipitators of homelessness in the majority of cases.

But that begs the question, for why were they doubled-up? Of those who left their own apartments (about 25% of all homeless families) 29% left because of high rents, 24% because of an unsafe building, 26% were evicted, and the remainder left for other reasons. Overall, about 8% of families become homeless because of fires. That housing-related incidents are the precipitators of homelessness in the majority of cases is the only possible result of the confluence of housing and economic factors cited earlier.

How Long Are They Homeless?

The average length of time that a family stays in emergency "transitional" shelter is 13 months.

Forty percent of homeless families have been in temporary housing for over one year.

The average length of time that a family stays in emergency "transitional" shelter is 13 months (Dumpson & Dinkins, 1987). The average is much shorter for families in shelters operated by non-profit organizations---four and six months respectively at the Red Cross Emergency Family Center and Women in Need shelters, for example, and much longer at some of the larger commercial hotels---18 months at the Martinique and the Holland Hotels. Forty percent of homeless families have been in temporary housing for over one year. Fourteen percent of all families have been homeless and in shelters for over two years (Dumpson & Dinkins, 1987).

These averages are deceiving, however. HRA data from Fall 1985 indicated that about half of all families leave within three to five months; the other half stay for an *average* of two years (HRA, 1988; D. Baillergeon, remarks to the Community Council of Greater New York, April 2, 1987). Long-term and short-term stayers seem to be different in some of their background characteristics (HRA, 1988; Baillergeon, April 2, 1987). Short-term stayers tend to be victims of fires, victims of domestic violence, and "other families experiencing traumatic events." Long-term stayers, on the other hand, have larger families, younger heads of households, and young children. Moreover, they have long histories of housing instability, and tend to lack independent living experience. In short, concludes HRA, "families with chronic problems fare less well" (1988, p. 8).

In short, concludes HRA, "families with chronic problems fare less well."

Another contributing factor may be the fact that the cases of many short-term stayers (if made homeless for the reasons noted above) are handled differently than those of the majority of long-term stayers. The City Department of Housing Preservation and Development (HPD) handles the re-housing caseloads of families made homeless due to fire or vacate orders (approximately 13% of all homeless families). And since about half of all HPD renovated units go to HPD's own caseload, HPD families have easier and faster access to city-owned housing than do HRA families.

HPD families have easier and faster access to city-owned housing than do HRA families. Homeless families on the HRA caseload are eligible for an in rem apartment only if they have been homeless for 18 consecutive months.

Homeless families on the HRA caseload are eligible for an *in rem* apartment (a vacant, City-owned apartment, taken by the City in tax foreclosure actions) only if they have been homeless for 18 consecutive months or if they have priority status; that is, if a family member is in the third trimester of pregnancy, or has an infant under six months of age. HRA noticed that soon after the priority categorization began to be implemented in 1986, the number of families with pregnant women and newborns began to increase. While this may have been coincidental, HRA is now beginning to re-think its services for pregnant women.

Perhaps because of the 18-month wait before becoming eligible to ride HRA's "housing van," only 20% of HRA's caseload are placed in city-owned housing. The remainder make their own arrangements (HRA, 1988).

Only 20% of HRA's caseload are placed in City-owned housing. The remainder make their own arrangements.

And after re-housing? HRA's estimate of recividism, i.e., the return rate of families back into the emergency shelter system after having been re-housed, is 10% (HRA, 1988). Anecdotal accounts, however, suggest a much higher figure.

SORTING OUT THE MAZE: SERVING HOMELESS FAMILIES

In this section we present an overview of the emergency shelter system. We begin with a brief description of the entry process into the system. We then describe the types and overall costs of shelter. Finally, we introduce the public agencies that serve homeless families.

The Process

The first stop of a homeless family seeking shelter from the city is at one of the 40 Income Maintenance (IM) Centers located throughout the city or at one of the four Emergency Assistance Units (EAU) in Manhattan, the Bronx, Brooklyn, and Queens. IM centers are welfare offices and so are only open during standard business hours. EAUs, on the other hand, which were created especially for the homeless, are open from 4 p.m. until 8 a.m. on weekdays and 24 hours on weekends and holidays. Each EAU serves about 30 families a night (City Council Subcommittee on the Homeless, 1987). Conditions at the EAUs have been described elsewhere. One report by the Coalition for the Homeless (1984) documented the daily scenario of 20 to 30 people, including infants and young children, literally spending the night on countertops, floors, and hard plastic chairs; limited to one sandwich per person per 8 hours, and one formula bottle and one diaper per infant over the same period. At one point in 1985, HRA acknowledged that about 2,000 children slept in EAUs during a single three-month span (Kozol, 1988).

HRA is working to change this. In 1984, HRA expanded the number of EAUs from just one in lower Manhattan to four. Families are no longer allowed to stay overnight. For those families who refuse a placement, a social worker is on site to counsel families to accept the placement. HRA projects that the average time it takes to refer most families is now two-and-one-half hours. The Manhattan and Bronx EAUs were co-located with barracks-style congregate shelters (called Tier I shelters) to speed shelter placements.

And from there? The referral of families to any of the city's 57 facilities is coordinated centrally by HRA's Housing Emergency Referral Office (HERO). Referrals are based on family composition and medical conditions.

Types of Shelters

There are three types of emergency shelter facilities for homeless families in New York City:

(1) *Tier I Congregate Shelters* are barracks-type facilities lacking private rooms for families. They are the City's first choice and families' last choice. An HRA survey indicted that 89% of shelter applicants would choose any kind of emergency shelter other than a congregate shelter (HRA, October 1986a). At one time IM Centers were much more likely than EAUs to refer families to Tier I shelters (HRA, October 1986b). HRA changed this practice after noticing that families tended to avoid the IM centers and returned repeatedly to the EAUs in hopes of obtaining placement in a hotel or Tier II shelter. Now, two of New York's EAUs (Manhattan and the Bronx) are co-located with Tier I shelters. The Brooklyn EAU is scheduled to be co-located by 1990 (HRA, 1988).

In addition to a place to sleep, state regulations require certain basic services at emergency shelters. Tier I shelters are regulated by Part 900 of the State Department of Social Services Regulations. At a minimum, a Tier I congregate shelter must provide access to three nutritious meals a day, supervision, and preliminary needs determination (e.g., health screening), and health services (e.g., referral capacity) (18 NYCRR Sec. 900.2). According to part 900, a family's stay in a Tier I facility is limited to 21 days. The family must then be referred to other emergency housing (see 18 NYCRR Sec. 900.7). However, according to some preliminary findings of the Citizens Committee for Children of New York (from an ongoing study on the quality of life at congregate shelters), neither the 21-day limit nor a limit on the number of persons per room (50) is being observed.

Five hundred thirty-eight families are sheltered in five Tier I facilities in Manhattan, Brooklyn, and the Bronx.

The regulations also stipulate that referrals to Tier I shelters cannot be made if a family member is pregnant, has a newborn, or has a communicable disease (Sec. 900.6, eff. July, 1986). In March and June, 1987 an injunction that prohibited the placement of families containing pregnant women and infants in barracks-style mass shelters was made final. Despite the City's concession in court that placement of these families was improper, the City has now filed a Notice of Appeal. The Court has directed that a hearing be held on this issue.

Five hundred thirty-eight families are sheltered in five Tier I facilities in Manhattan, Brooklyn, and the Bronx (see Table 1).

(2) *Tier II Shelters* offer families private sleeping accommodations with private or shared bathroom facilities and congregate dining; others (Family Centers) are set up as small apartments, complete with kitchen facilities. Tier II shelters often restrict eligibility (e.g., no men, *no children over age 8*, no drugs, no violent behavior). There are 26

Table 1

Families in Emergency Shelter in New York City
November 26, 1987

Borough	Number of Facilities	Number of Families Sheltered	
Manhattan			
Tier I	2	247	
Tier II	9	408	
Hotels	23	2147	
TOTAL	34	2802	(54.8%)
Brooklyn			
Tier I	2	237	
Tier II	9	156	
Hotels	9	500	
TOTAL	20	893	(17.5%)
Queens			
Tier I	0	0	
Tier II	3	210	
Hotels	15	567	
TOTAL	18	777	(15.2%)
Bronx			
Tier I	1	54	
Tier II	4	217	
Hotels	6	151	
TOTAL	11	422	(8.2%)
Staten Island			
Tier I	0	0	
Tier II	1	77	
Hotels	4	145	
TOTAL	5	222	(4.3%)
City Totals			
Tier I	5	538	(10.5%)
Tier II	26	1068	(20.9%)
Hotels	57	3510	(68.6%)
TOTAL	88	5116	(100.0%)

Source: City of New York Human Resources Administration (1987, November). *New York City Temporary Housing Program for Families with Children.* Monthly Report.

Tier II facilities which shelter 1,058 families among the five boroughs.

Tier II facilities and family centers are required to provide a richer complement of services than Tier I facilities, including in addition to the services required in Tier I shelters, permanent housing preparation services, recreational services, information and referral services and child care services (18 NYCRR Sec. 900.2). In addition, families at Tier II facilities and hotels get a restaurant allowance.

Commercial hotels shelter over two-thirds of New York City's homeless families.

(3) *Commercial Hotels* shelter over two-thirds (3,510) of New York City's homeless families. The majority of hotels are located in Manhattan and Queens. They provide a family with a room (or two, if the family is large enough), and either private or shared bathroom facilities. (See Table 1 for the distribution of facilities citywide.) Regulations for hotels as transitional shelters are essentially limited to sanitation and maintenance requirements (see 18 NYCRR Sec. 352.3). However, all homeless families, regardless of type of shelter have continuing entitlement for public assistance, Medicaid, food stamps, and other benefits for which they are eligible (e.g., WIC, unemployment benefits).

As part of its "Five-Year Plan for Housing and Assisting Homeless Families" HRA "plans to eliminate its use of commercial hotels...eliminate Tier I facilities...[and] increase reliance on Tier II facilities."

Though the majority of New York's homeless families are sheltered in hotels, as part of its "Five-Year Plan for Housing and Assisting Homeless Families" HRA "plans to eliminate its use of commercial hotels...eliminate Tier I facilities...[and] increase reliance on Tier II facilities" (1988, p. 40). The feasibility of that plan is currently under debate but at least over the last year, as the overall number of homeless families has increased, there has been a distributional shift in the placement of families in emergency housing. The percentage of families in Tier II facilities increased from 9% in August 1986 to 21% 15 months later. At the same time, the percentage of families sheltered in hotels declined from 80% in August 1986 to 69% in November 1987 (though their overall numbers increased). The percentage of families in Tier I facilites stayed the same (10% at both times).

Two-thirds of homeless families entering the shelter system come from the Bronx and Brooklyn; over half of them will end up in shelter facilities in Manhattan.

Where Do Homeless Families Come From and Where Do They Go To?

Two-thirds of homeless families entering the shelter system come from the Bronx and Brooklyn; over half of them will end up in shelter facilities in Manhattan (see Table 2). This is in spite of state regulations specifying that "[a]ny referral [to Tier I or Tier II facilities] must be made in light of the community ties and educational needs of the family and the children in the family" (18 NYCRR Sec. 900.7). Hotel referrals are also required to take account of "factors which will insure the minimum disruption of community ties" (18 NYCRR Sec. 352.3).

Most families are simply cast adrift away from their neighborhoods, without any of the social supports that their former homes offered.

Some families go to great lengths to maintain those ties. We heard about an employed homeless mother who every morning went from her shelter on the west side of Manhattan to drop her daughter off at her day care center in the Flatbush area of Brooklyn where they formerly lived, and from there would go to her job in lower Manhattan. When, after six months, she was re-housed, it was to an apartment in the Bronx, and for awhile at least, she continued the same commutation pattern---from the Bronx. She said that she did all of this (including paying transportation costs of $40/week) in order to reduce the stress on her child; to ensure that there would be some stability in her daughter's life. Most families, however, are simply cast adrift away from the familiar ties of their

Table 2

Location of Emergency Shelter in Relation to Families' Borough of Last Residence

Borough	Last Permanent Address *	Location of Families in Emergency Housing **
Manhattan	20.7%	54.8%
Bronx	26.3%	8.2%
Brooklyn	40.3%	17.5%
Queens	12.1%	15.2%
Staten Island	0.5%	4.3%

Note: These percentage distributions are not directly comparable since they were done at different times, but the distribution of families' borough of last residence is not expected to have changed significantly over the period between the two reports.

Sources:

* City of New York Human Resources Administration (1986, March). *Averting the Need for Emergency Housing: The Feasibility of an Early Warning System for Public Assistance Families.* Project Bulletin.

** City of New York Human Resources Administration (1987, November). *New York City Temporary Housing Program for Families with Children.* Monthly report.

former neighborhoods and without any of the social supports that their former homes offered.

New York City is spending $354 million, including $129 million in City funds, to shelter the homeless.

The Costs of Shelter

In the current fiscal year, New York City is spending $354 million, including $129 million in City funds, to shelter the homeless (*New York Times*, January 26, 1988).

The monthly cost for sheltering New York's 5,116 homeless families is approximately $8.5 million.

To shelter families, the total costs may well exceed $150 million. The City and State each pay one-quarter of the costs. The remainder is reimbursed by the federal government through the Emergency Assistance to Families (EAF) Fund, administered by the Department of Health and Human Services. The bulk of the money goes to nightly shelter costs---and it isn't cheap. As shown in Table 3, the monthly cost for sheltering New York's 5,116 homeless families is approximately $8.5 million, not including the delivery of any supportive services. The hotels are apparently the winners in this. At the Hotel Martinique, the daily rate for a family of four is $63.11/day.

Homelessness is a high profit industry. The irony is not lost on families---who must deliver a rent check to the hotel management twice a month---that the costs of sheltering them in an 11-foot-square room is triple the costs of what they were once paying---or would like to be paying ---in rent.

> "[I found an apartment.] The rent was $365. [the landlady] said that she would skip the extra month and the deposit...This lady likes me and we're going to have a home! [Then m]y worker denied me for $365. I was denied. $365. "Your limit is $270." Then I thought of this: the difference is only $95. I'll make it up out of my food allowance...Do you know that they are paying $1,900 every month for me to stay here? Sixty-three dollars every night. So for two nights you'd

Table 3

Average Costs of Sheltering Homeless Families in New York City

Type of Facility	N of Families Sheltered	Average Cost per family/ month	Est. Total cost/month
Tier I	538	$1,989 (a)	$1,070,082
Tier II	1068	$1,041 (b)	$1,111,788
Hotels	3510	$1,800 (c)	$6,318,000
TOTALS	5116	$1,661	$8,499,870

Note: These are average costs for sheltering a family of four. The overall cost per family per month is a weighted average.

Sources:

(a) Council of the City New York Select Committee on the Homeless (1987, January). *Report on the Homeless Crisis*, p. 86.

(b) Council of the City of New York Select Committee on the Homeless (1987, January). *Report on the Homeless Crisis,* p. 84. This is an upper-range estimate of what are $34-$41/night average costs.

(c) City of New York Human Resources Administration, (1988, January). *Five-Year Plan for Housing and Assisting Homeless Families*, p. 19.

> have the $95 right there. I told my social worker that. I said it don't make sense and he agreed with me but he is not the one who makes the rules..." (Kozol, 1988, pp.42-43)

A multitude of city agencies have responsibility for one phase or another of a homeless family's daily life.

The State has just raised the monthly housing allowance for welfare recipients by an average of 13%. However, this is unlikely to make up the difference for a significant number of low-income renters---over half of whom pay an average of $75/month more in rent than the shelter allowance allows (*New York Times*, December 28, 1987). A family of four trying to pay a rent of $365/month, would still be short by $53 even with the raised ceiling. And a life of poverty has other ironies as well. For every $3 increase in the shelter allowance, food stamp payments drop by about $1.

Agencies Serving Homeless Children and Their Families

A multitude of city agencies, within four major departments, have responsibility of one phase or another of a homeless family's daily life.

(1) THE HUMAN RESOURCES ADMINISTRATION (HRA), as the City department that administers social welfare programs, is the one with the most programmatic responsibility for homeless families, including both their immediate emergency shelter needs as well as other social welfare needs. Within HRA:

> The ADULT SERVICES AGENCY (ASA) has executive responsibility for directing shelter services. Within ASA, *Family and Adult Services* administers the shelter programs for homeless individuals and *Crisis Intervention Services (CIS)* the shelter program for families. CIS oversees the shelters themselves as well as the four Emergency Assistance Units (EAU),

usually a family's first stop in the process of seeking emergency shelter.

The INCOME ASSISTANCE AGENCY provides income maintenance, food stamps, and other entitlement benefits. It is to any of the City's 40 Income Maintenance (IM) Centers that homeless families and other poor people go for public assistance and other income support services. For homeless families, this includes Aid to Dependent Children (ADC), Emergency Assistance to Families (EAF) for families not on welfare, food stamps, the bi-monthly hotel rent checks, and miscellaneous cash benefits (e.g., the restaurant, transportation, and furniture allowances). The hotel and Tier I caseworkers are employed by CIS.

FAMILY AND CHILDREN'S SERVICES AGENCY (FACSA) was established to coordinate family and children's services and child welfare responsibilities within HRA. Within FACSA, *Special Services For Children (SSC)* has as its primary responsibility the investigation of reports of child abuse and neglect. It also administers preventive services and the foster care system; the provision of both is largely contracted out. Homeless children are served through SSC programs primarily if they are referred to SSC for potential abuse and neglect.
The *Agency for Child Development (ACD)* has full administrative and funding control over publicly-funded day care (both center-based and family day care) and Head Start programs---which presently include 873 targeted slots for homeless children. The *Office of Family Services*, with offices in almost every one of the city's 59 community districts, has

primarily a case management/home visiting function for four targeted groups of families, including newly re-housed homeless families.

(2) The DEPARTMENT OF HOUSING, PRESERVATION AND DEVELOPMENT (HPD) manages City-owned properties. In particular, it is the agency with responsibility for rehabilitating City-owned vacant apartments for homeless families. In addition, it handles within the *Division of Relocation* the caseloads of families made homeless due to fire or vacate orders (about 13% of all homeless families).

(3) The DEPARTMENT OF HEALTH (DOH) administers the Homeless Health Initiative (HHI) within the *Bureau For Families With Special Needs*. The HHI was established in 1986 to coordinate specially targeted services to homeless individuals and families. Included among its staff are the 25 Public Health nurses who service the welfare hotels.

(4) The NEW YORK CITY BOARD OF EDUCATION has created a Hotel Unit within its *Office Of Student Progress* to provide and coordinate services for the more than 6,000 school-aged children residing in temporary housing.

The following sections describe in more detail the systems and services that are available to homeless families and children. We begin with health in the belief that other programs and services are irrelevant if primary health care needs are not met.

HEALTH CARE FOR HOMELESS CHILDREN

> "Of course these children are behind in school. When you are dehydrated from continuous diarrhea, wheezing from untreated asthma, exhausted after being kept awake all night from the noise in the hotel, and hungry from not having eaten a real meal for days, it's hard to get excited about learning the ABCs."

This statement, from a day care teacher of homeless children, describes many children living in the welfare hotels and shelters of New York City. Homeless children are sick at rates many times higher than the average child and often their illnesses go untreated until they become serious, even life threatening. An example of a young mother living in one of the Tier II shelters run by a not-for-profit organization illustrates the severity of health problems:

> Mrs. L spent a weekend in the hospital where all three of her children were hospitalized. Both infant twins were admitted: one awaiting surgery for a birth defect that had hospitalized her since birth and the other for double pneumonia. The 2 1/2-year-old was being treated for dehydration from diarrhea, the third time in five months that she had been hospitalized for this problem.

Uncontrollable diarrhea is very common in young homeless children. During interviews with directors and teachers of day care for homeless children, diarrhea was mentioned again and again as a recurring problem often leading to hospitalization and a main cause of school absence. Further, teachers were quick to point out which children had been hospitalized repeatedly for diarrhea. A 3-year-old who had been hospitalized three to four times was not uncommon.

Infants born into homelessness are at-risk even prior to taking their first breath.

More than half of all pregnant women living in welfare hotels in 1985 had minimal or no prenatal care.

A Fall/Winter 1986 survey of families at EAUs showed that out of 54 households surveyed, 30 children had been diagnosed as having diarrhea as a diet-related problem (Dehavenon, 1987). Diarrheal dehydration is the leading cause of death among children worldwide, killing 3 million yearly. Diarrhea has traditionally been thought of as a disease of third world nations. One of the main goals of UNICEF over the past seven years has been to stop these deaths by distributing an inexpensive fifty-cent packet of sugar and vitamins. This oral rehydration program has been widely successful in developing nations (Grant, 1988). Yet here in one of the world's most advanced countries, poor children suffer needlessly from this easily curable disease.

Infants At-Risk

Infants born into homelessness are at risk even prior to taking their first breath. The lack of prenatal care for homeless women puts infants at great risk of health problems, low-birthweight, failure to thrive, and early death. The New York City Department of Health (Chavkin, Kristal, Seaborn, & Guigli, 1987) reported more than half of all pregnant women living in welfare hotels in 1985 had minimal or no prenatal care, twice the rate statewide, which at 27.6% ranks New York State 42nd in the Nation for prenatal care (*CDF Reports*, January 1988). The number of women receiving prenatal care in 1988 can only be less due to the increase in the number of homeless families and the lack of available prenatal services (Chavkin, Kristal, Seaborn & Guigli, 1987).

The consequences of poor prenatal care are severe. One out of six, or 16.3%, of the infants born to mothers living in welfare hotels from January, 1982 to June, 1984,

One out of six infants born to mothers living in welfare hotels was low-birthweight.

was low-birthweight. This is more than double the rate of 7.4% for low-birthweight infants born to all other mothers in New York City, excluding those living in housing projects, during this same period (Chavkin, et al., 1987), and 7.0% for New York State as a whole (*CDF Reports*, January 1988).

Low-birthweight is the leading cause of infant deaths during the neonatal period, i.e., the first 28 days of life (*CDF Reports*, January 1988). When coupled with a poor living environment, low-birthweight is known to cause major handicapping conditions including hearing and visual impairment, mental retardation, and behavior and learning problems (Escolona, 1982). Further, it has been shown that children who are environmentally at-risk, whose early childhood opportunities for secure maternal attachment and health care, as well as opportunities for physical, social and adaptive stimulation are limited, present a high risk for future developmental delay. Although factors such as maternal education and the quality of the mother-child relationship can act as mediators, environmental risk conditions, such as those mentioned above have been highly correlated with delayed development including mild retardation, delayed motor milestones, and restricted expressive and receptive language abilities (Meisels & Anastasiow, 1982). Prenatal care not only saves lives, it carries a cheap price tag as well. The cost for decent prenatal care for a pregnant women is $500. In contrast, treatment for a low-birthweight infant can easily exceed $100,000 (*New York Times*, February 13, 1988).

The increase in drug use by pregnant women further jeopardizes the well-being of the helpless newborn. Although data are not available for homeless infants, a *New York Times* article (February 13, 1988) reports that nearly

20% of the infant deaths in Central Harlem during 1986 were caused by cocaine. Similar findings were reported in other poverty pockets of the city. Further, between 1980 and 1985, there was a 60% increase citywide in the number of babies born to drug addicted mothers. In Central Harlem, the infant mortality rate has increased by 73% since 1984, the year crack invaded this poverty-stricken neighborhood.

Between 1980 and 1985, there was a 60% increase citywide in the number of babies born to drug addicted mothers.

During our interviews with directors of day care programs for preschool-aged homeless children, virtually everyone identified drug use as a major problem with homeless mothers. With so many babies born into homelessness, the unborn child and newborn infant become the tiniest victims of a drug abuse epidemic. The consequences are severe for the newborn and it is the larger society that will pay the price, both financially and socially, to care for these victims.

In our program visits, we saw a 3-year-old child who had been a heroin withdrawal baby. At 3, she had practically no language skills. Born to an addicted IV-drug user, she had lived on the streets and in abandoned buildings with her drug abusing parents before being taken into custody by a relative who was homeless.

The infant mortality rate (deaths during the first year of life per 1000 live births) is generally regarded as the best statistical indicator for the well-being of vulnerable populations. In recent decades, that rate has fallen for all nations, but relative rankings for the U.S. have progressively worsened. Further, differences for rates in the U.S. between Blacks and Whites and poor and non-poor have greatly widened. In comparison to European nations, the overall infant mortality rate (IMR) for the U.S.

of 10.6 is higher than that for 15 European nations (Miller, 1987). In New York City in 1984, the IMR for infants born to mothers in welfare hotels was an alarmingly high 24.9 (Chavkin et al., 1987), worse than the developing nation of Trinidad and Tobago where the rate in 1986 was 24 deaths per 1000 live births (Grant, 1988), and double the rate of 12.0 for all others in New York City. These rates may actually be even higher today. A recent *New York Times* report (February 13, 1988) stated that the IMR for New York City had increased in 1987 to 12.9, and the IMR for Central Harlem in 1986 was 27.6. Conditions in welfare hotels are comparable to or worse than Central Harlem, making it likely that the IMR for babies born into homelessness is higher than 27.6.

In New York City, the infant mortality rate for infants born to mothers in welfare hotels in 1984 was an alarmingly high 24.9.

Infants who do survive will be vulnerable to unsanitary living conditions, lack of food and health care, and at high risk of lead poisoning. Mothers are often without refrigeration and have no place to store infant formula. A survey at New York City EAUs showed that 13 out of 23 families using infant formula had to dilute the formula in order to provide enough for their child (Dehavenon, 1987). HRA (1988) reports that 83% of the pregnant women with newborns were provided with refrigerators for storage of food and infant formula. This leaves 17% of all pregnant women and women with newborns without any refrigeration for infant formula.

Gastroenteritis is one of the most common reasons for homeless infants being admitted to hospitals, often resulting from the ingestion of harmful bacteria from stale infant formula and unsterilized bottles.

When an infant does become sick, lack of medical care can lead to severe illness. The National Coalition for the Homeless, cited in a U.S. House of Representatives fact sheet on homelessness (Select Committee on Children, Youth, and Families, n.d.) listed gastroenteritis as one of the most common reasons for homeless infants being admitted to hospitals, often resulting from the ingestion of harmful bacteria from stale infant formula and unsterilized bottles. One homeless mother reports her year-old son's chronic asthma (requiring daily medication, breathing machines and round-the-clock monitoring) as the result of severe lung damage brought on by double pneumonia at six weeks of age. He has been hospitalized 12 times in his first year of life.

The general patterns of illness are not uncharacteristic of children's illnesses in general, although the absolute rate at which most of these disorders occur among homeless children is inordinately high.

Health Problems in Homeless Children

Close living quarters, poor nutrition, lack of medical care, and non-immunization create breeding grounds for what are commonly known as easily treatable or curable diseases. At the Roberto Clemente Shelter (closed in September, 1986, due to the inhumane living conditions), a chicken pox and measles outbreak occurred in June, 1986. Given the barracks-style situation, it was nearly impossible to contain the spread of these very serious diseases (Council of the City of New York, Select Committee on the Homeless, 1987).

The first report from the National Health Care for the Homeless (HCH) project (Wright, Weber-Burdin, Knight, & Lam, 1987) documented that the general patterns of illness among homeless children are "not uncharacteristic of children's illnesses in general, although the absolute rate at which most of these disorders occur among homeless children are inordinately high" (p. 62). Listed as the most common disorders observed among homeless children (in order of frequency) were: minor upper respiratory infections, minor skin ailments, ear disorders, gastrointestinal problems, trauma, eye disorders, and lice infestations. Most of the disorders were at least twice as common among HCH children as among NAMCS (National Ambulatory Medical Care Survey) children. Fifteen percent of the children (vs. 9% of the NAMCS) already exhibited one or more chronic health problems, such as cardiac disease, peripheral vascular disorders, and neurological disorders. It should be noted, however, that patients were essentially self-selected and only 10% were children under age 15. Nonetheless, even given the older age distribution and the possibility that many patients may have had pre-existing conditions, the researchers concluded that the largest share in the observed illness patterns must be ascribed to the deleterious effects of homelessness itself on physical well-being.

In a sample of 110 homeless children seen at a New York City hospital, 25% were anemic; 5% suffered from serious growth failure; 50% had recurrent respiratory infections, and 29% had ear infections.

To date, there is little systematic data on the rates of illness for children living in welfare hotels. The data that have been collected suggest that these children are faced with a much greater risk of disease and illness than other children. Further, because the data on health problems in homeless children were collected from records of children seen at clinics, the actual incidence of health problems is probably much higher. These statistics do not account for the many thousands of sick homeless children not receiving medical care. Nonetheless, the rates are alarming. In a sample of 110 homeless children seen at a New York City hospital, 25% were anemic; 5% suffered from serious growth failure; 50% had recurrent respiratory infections, and 29% had ear infections (U.S. House of Representatives, Select Committee on Hunger, 1987). Health care providers on the New York Children's Health Project medical van (a mobile medical unit that brings medical care to children in welfare hotels) cited similar problems. In a *New York Times* article (January 27, 1988), non-immunization, malnourishment, anemia, lead poisoning, lice, asthma, pneumonia and untreated ear infections were mentioned as health problems in these children.

A 75% rate of under- or non-immunization was found in a cross-age group of children living at the Hotel Martinique. Among a comparative sample of housed, poor children, the rate of non- and under-immunization was 8%.

Under- and non-immunization is another major problem for homeless children. Without legally required immunizations, preschool children are unprotected against many harmful, crippling and life threatening childhood diseases. All children must be immunized before they are allowed to attend school in America, thus keeping the non-immunized rate to a minimum, ranging from 0.9% for DPT to 28% for rubella (Hughes, Johnson, Rosenbaum, Butler & Simons, 1988). In shocking contrast, a 75% rate of under- or non-immunization was found in a cross-age group of children living at the Hotel Martinique. Among a comparative sample of housed, poor children, the rate of non- and under-immunization was 8% (G. Alperstein, Bank Street College Research Roundtable, November 19, 1987). By comparison, El Salvador, an underdeveloped, war-torn country, had three days of cease fire in order to use all workers and soldiers to immunize their children. Colombia, having only 20% of their young immunized, launched a major campaign to immunize all children under age five. Within one year, almost 100% of the children had been immunized (L. Ullman, speech delivered at 92nd Street "Y", September 27, 1987). There is a bitter irony when a country with the ability to perform organ transplants and open heart surgery, and the resources to bring people from foreign nations to undergo life saving operations not available in their own country, is not willing to protect its most vulnerable population: the young.

Health Care Providers

There are a number of health care providers in New York City providing health services specifically to the homeless and, more particularly, to homeless children. However, the services are limited, uncoordinated, and leave many children with no health care at all. Children and Youth clinics at hospitals throughout the city provide medical care

Services are limited, uncoordinated, and leave many children with no health care at all.

for homeless children; neighborhood clinics serve some hotels; mobile medical units such as Betances and the New York Hospital Health Van go directly to hotels; programs like Visiting Nurse Services and Public Health Nurses visit families at the hotels; and at least one hotel has a dental or health clinic on site, although the hours of operation are limited. There are currently 25 nurses serving 37 hotels as Public Health nurses. These nurses do not directly provide health care; rather, their responsibilities include health assessment, education, counseling and referrals (N. Tobier, personal communication, February 5, 1988).

Even with the different health care programs available, many homeless children remain non-immunized, sick, or without medical attention. This is due, in part, to the fragmented system and lack of comprehensive, coordinated health services for the homeless in New York City. There is no central coordinating office for homeless health care, nor does the city have anyone on staff to coordinate the different health programs and to act as a liaison between health care providers. Consequently, some hotels are serviced by multiple providers who do not necessarily work together to coordinate their services and maximize benefits, while other hotels do not have any medical services targeted to them. The fragmented services result in an inequitable system where health care is easily accessible to only a few. For the majority of homeless families health care services are not easily accessible, leaving thousands of children sick, infected, and without medical care. Information regarding these services is often minimal and difficult to obtain.

Follow-up and continuity of care is nearly impossible as people are moved to different hotels. An integrated system could be made possible by computerization of provide quick access to the files for all health care workers as well as a history of the medical care a person has received. Further, with records in one central place, files would not be lost or difficult to find each time a family moves.

Special Initiatives

Special attention should be given to several important health initiatives in the city, which are beginning to develop innovative approaches to serving homeless children and families.

New York Children's Health Project. The New York Children's Health Project, associated with the New York Hospital-Cornell Medical Center, receives private funds as well as federal to operate a mobile medical van. The van currently serves 13 hotels, serving each hotel once per week on the same day. If a referral is needed, a child is referred to New York Hospital or to his/her provider if requested. By parking outside the same hotel each week, follow-up and continuity of services is made possible. A computerized data collection system, including an immunization tracking system is being implemented along with establishing a network of pediatricians to make sure that all children have an identified health provider (N. Tobier, personal communication, February 5, 1988). Plans for a second van to serve Queens and other boroughs are currently underway.

The Homeless Health Initiative. In order to address the problem of health care for the homeless, the City of New York established the Homeless Health Initiative (HHI) in Spring, 1986. The aim of this initiative is:

(1) To identify and to address the unmet health needs of the city's homeless population

(2) To develop and to recommend policies and standards which will have a positive impact on the health status and physical environment of the homeless population

(3) To implement surveillance systems which monitor relevant health and environmental outcomes; and

(4) To develop and to maintain cooperation and interaction among agencies and institutions serving homeless people.

Under this initiative, prenatal care pilot programs have been established at four hotels as well as a monitoring system aimed at decreasing the infant mortality rate. Also operating under this initiative is the Family Shelter Health Program aimed at improving the health of homeless families through preventive intervention (City of New York Department of Health, n.d.). Public Health nurses are a part of this program. Although the city has expanded this program (there are approximately 25 nurses systemwide [HRA, 1988]), caseloads for a Public Health Nurse are large (25 : 3500) due to the many people requiring services, thus limiting the time a nurse can spend with any one client.

The National Health Care for the Homeless Program. One program that has taken an approach to comprehensive health care for the homeless is the National Health Care for the Homeless (HCH) Program. The program was started by the Robert Wood Johnson Foundation and the Pew Memorial Trust as a community-based health care program in 19 cities including New York City. The programs operate out of shelters, soup kitchens, community centers, and other places where the homeless spend time. Although the goal is to bring health care to the homeless, a major feature of the program is a concern not only for health, but also for the wide range of other problems faced by the homeless. The HCH "demonstrates that even the most disadvantaged among the homeless can be integrated into a system of care and that health care can be an important 'wedge' into more basic social, psychological and economic problems" (Wright et al., 1987, p. 16). This program has been successful in reaching the homeless and should be recognized as a model for other programs to follow.

Given the high incidence of disease and illness in this population, the urgent need for a comprehensive health care program that reaches all homeless children and families must be emphasized. In our visits to programs for homeless children we saw a 2 1/2-year-old with no front teeth because they had rotted away, a mother whose infant had died of AIDS, and numerous 2- and 3-year-olds who had been hospitalized for pneumonia, asthma, diarrhea, worms, and fevers. These are children whose lives are already chaotic. Limited health care and frequent illness bring further disruption and instability into their lives. Models such as those highlighted above should be expanded and coordinated with existing services and providers. It is imperative that a health care system accessible to *all* children be implemented.

NUTRITION

> "I'm lucky. I have a 2-burner hot plate in my room. The only problem is I have to make a lot of fried foods and that's not good for D. (her 4-year-old daughter) at every meal. I dream of having an oven to bake her chicken, and a nice cake." (A homeless mother of one)

Preparing meals is a major problem for homeless families in welfare hotels. A majority do not have any cooking facilities but many illegally use hot plates in their rooms. With limited money for food and minimal cooking facilities, adequate nutrition is a major problem for homeless families.

Many of the City-run welfare hotels are located in midtown Manhattan. The hotels are surrounded by office buildings with accounting firms, law offices, wholesalers, manufacturers, investment banking firms, and other businesses. On any given block that houses a welfare hotel, it is likely for one to find expensive clothes boutiques, fine restaurants and cafes, shoe stores or gift shops. Finding a grocer, laundromat, or drug store is much more difficult. The few in the area charge prices beyond what a mother in a welfare hotel can afford, forcing her to pay the expensive prices or travel long distances to buy groceries or do laundry at a "fair" price. "The grocer across the street raised the prices on staple foods like milk and bread as soon as this hotel started housing the homeless," a director of an on-site day care center told us during one interview. "Nobody shops in this neighborhood, they have to go uptown or downtown. Shops are too expensive here," another director said of the neighborhood surrounding a large welfare hotel. Tenants of one midtown hotel

Tenants of one midtown hotel returned to the Bronx, Brooklyn or the Lower East Side in order to shop, a long trip, especially with children.

returned to the Bronx, Brooklyn or the Lower East Side in order to shop, a long trip, especially with children. Tenants confirmed that food prices near the hotel were extremely high and local grocers did not accept food stamps (Simpson, Kilduff, & Blewett, 1984). We checked prices for groceries on the block of a midtown welfare hotel. Milk was $1.69 for a half-gallon. A half-gallon of milk on the Upper West Side was $1.21.

Supplemental Food Programs

A restaurant allowance of $16/person/week translates to $2.13/day or 71 cents/meal if three meals are eaten.

Food Stamps. Homeless families qualify for several types of assistance to help purchase food. First, they qualify for food stamps. However, since the family is living in a welfare hotel and does not have cooking facilities, their food stamp allotment may be reduced from the amount they received when housed. The City provides them with a restaurant allowance to help make up the difference. HRA gives a restaurant allowance of $16/person/week which translates to $2.13/day or 71 cents/meal if three meals are eaten (personal communication, February 9, 1988). $2.13 can buy a Whopper at Burger King, not much food for one day. In addition, a mother with one child can receive $11/week in food stamps to help with the restaurant allowance, giving her an additional $1.58/day in food stamps.

But many do not even get this. Although the application process should be expedited for any homeless person, according to a staff member in New York City's Bureau of Nutrition (personal communication, February 8, 1988), a government survey of 2,112 individuals in family shelters in New York City who were eligible for food stamps found that 49% were not receiving them (U.S. House of Representatives Select Committee on Hunger, 1987).

Once a mother has purchased food, preparing the meal becomes a very difficult task. Meals prepared on a hot plate can only be cooked one food at a time, so food must be eaten sequentially rather than together as a meal. Space is very limited, requiring beds and floor space to be used for eating. "Some people spread newspapers on beds and use it as a table," (Simpson, et al., 1984, p. 25). The bathroom is used for cleaning up; in some hotels this requires a trip down the hall to the communal bathroom. Even if a family has its own bathroom, this still means using the same area for food clean-up as for personal hygiene, not a sanitary arrangement. A change in the food stamp statute enacted in Public Law 99-570 will permit the homeless to voluntarily use food stamps for the purchase of prepared meals at certified non-profit feeding establishments. This change could relieve some of the burden homeless families face in trying to prepare meals without any real cooking facilities.

According to a government survey of 2,112 individuals in family shelters in New York City who were eligible for food stamps, 49% were not receiving them.

Emergency Food Programs. In order to assist families with food and nutrition problems, both the New York State and federal governments have established nutrition programs to provide funds for emergency foods. The emergency food and shelter program, administered through FEMA (the Federal Emergency Management Agency) provides money for food and shelter programs. The money is distributed through the Greater New York Fund to local providers, and is applied for through a competitive grants process. Now in its sixth year of operation, FEMA provided $3,424,000 to New York City-based programs for the current fiscal year. The Supplemental Nutrition Assistance Program (SNAP) is a State-funded program which allocated $49 million throughout the state during FY87. Of the total allocation,

$30.7 million was for State supplementation of WIC (a federal program discussed below, that the State chooses to supplement in order to serve more people), $6.5 million for the destitute and homeless, and the remainder for the elderly. SNAP funds are distributed to the Greater New York Fund, the Food Bank, and statewide demonstration programs. The Greater New York Fund uses money to fund soup kitchens, food pantries, and emergency food at shelters run by private not-for-profit agencies. The City also has a nutrition program, called the Emergency Food Assistance Program (EFAP), which distributes City-purchased foods to soup kitchens and food pantries. The program gave $2 million to 393 groups during the current fiscal year. Both the State and federal governments have programs for the distribution of surplus foods to poor and homeless families. For example, the Food Bank is a warehouse of company donated foods that are sold to programs at 10 cents/lb. However, data were not available on how many people are served (L. Krueger, Community Food Resource Center, personal communication, February 9, 1988).

School Meals Programs. Children who attend the public schools are eligible for school breakfasts and lunches. The U.S. Department of Agriculture (USDA) food program provides funds to continue the breakfast and lunch programs during the summer months when schools are closed. This same program provides funds to day care centers and summer camps to purchase food for meals.

WIC. A nutritional program for which many homeless mothers and children are eligible is the Special Supplemental Food Programs for Women, Infants and Children (WIC), a totally federally funded program. As mentioned earlier, New York State has opted to supplement the program to serve more people. This program provides food supplements (including milk, eggs, infant formula) to pregnant women, postpartum women (up to six months after delivery), nursing mothers, and infants and children up to age 5. Specific income standards must be met as well as certain nutritional criteria such as low-birthweight, failure to thrive, or vitamin deficiencies. According to a worker in a New York City WIC office (personal communication, February 9, 1988), "This is a preventive program, so most homeless families qualify due to the poor nutritional content in their diets. Many poor families who are housed qualify, too. The requirements do not mean a severe condition must be present: even a lack of certain vitamins qualifies." Vouchers specifying eligible food items are distributed to WIC-eligible families. There are WIC offices throughout the city at hospitals, health centers, and Department of Health child health stations. Statistics for New York City could not be located, but in New York State, according to Lynn Krueger of the Community Food Resource Center (personal communication, February 9, 1988), 680,000 women, infants and children are eligible for WIC and only about one-half are receiving it. Figures on the percentage of homeless children using WIC are not available. Only one hotel (the Prince George) has a WIC office on site.

In New York State, 680,000 women, infants and children are eligible for WIC and only about one-half are receiving it.

Other Meal Programs. Other programs that provide meals for homeless children and families include the Coalition for the Homeless. The Coalition serves lunch five days per week at three welfare hotels: the Martinique, Prince George, and Holland. According to Tom Styron of the Coalition for the Homeless (personal communication, February 5, 1988), approximately 300 meals are provided at each hotel each week day, serving about 300 adults and 700 children daily. The Salvation Army serves lunch daily to families at the Brooklyn Arms. The families are bused to another site for the meals because they are not allowed to serve them at the hotel (L. Krueger, personal communication, February 9, 1988). The *Five-Year Plan for Housing and Assisting Homeless Families* (HRA, 1987) mentions that HRA established the hotel dining program in December of 1985 in five hotels. Nearly 190,000 meals were served in FY 1987. By serving 1,000 lunches each weekday, the Coalition for the Homeless serves about 250,000 lunches per year. Between the two programs, less than 1,800 people receive meals in the hotels each day.

Hungry Children

Although there are food programs available to serve the homeless, the programs do not meet the demand for food to feed everyone and malnutrition is one possible consequence.

Myron Winick (1985), a professor of nutrition at Columbia University, describes the effects of malnutrition:

> "If calorie and protein intake is insufficient, the result is often referred to as protein-calorie malnutrition. This type of malnutrition will cause a series of changes within the body that, if not corrected, can lead to progressive deterioration and death. Fat tissue is completely consumed, muscle mass is markedly reduced, water is lost from the cells and accumulates between them and sometimes within the body's cavities, heart rate slows, blood pressure drops, temperature is subnormal, and the patient responds by doing whatever is necessary to conserve the body's energy. A person suffering from protein-calories malnutrition shows apathy, slower movements, and decreased activity." (p. 103)

Although there are no systematic data to support this, we noticed in our early childhood program visits just how *tiny* the children were. Overall, they seemed much smaller in stature than a comparable group of more advantaged children.

Day care directors and teachers noted that some children might not eat if it weren't for their meals in day care.

Day care directors and teachers repeatedly noted how hungry children were and that some children might not eat if it weren't for their meals in day care. During our visits to day care programs, we observed tiny, undersized 2- and 3-year-olds eating three bowls of cereal at breakfast, two hamburgers for lunch or requesting a third helping at a meal. These were clearly children who were very hungry. "Mothers are often hungry, too," observed one teacher, "one mother today asked if we could give her breakfast because she hadn't eaten in over a day."

At one day care center, extra food from lunch was put out for mothers to take. One mother came to get food even though her child was sick and had not attended that day. Other mothers arrived early to pick up their children in order to be assured that they got food before it ran out. A haunting example of the need for food comes from the description by a teacher, of a 3-year-old homeless child arriving at the day care center in the morning,

> "He would come in here daily kicking and crying uncontrollably. He'd throw himself on the floor, out of control. Even our assurances that breakfast would be served shortly couldn't quiet him down. He was starving. As soon as breakfast was on the table, he'd quiet down and eat, two or more bowls of cereal."

A similar scene was described by a teacher in another program.

> "Initially, she (a 3-year-old) would come into the room screaming, kicking her feet and flailing her arms in an uncontrollable

> tantrum. When we'd sit her down to eat, she'd throw the food across the table hitting at everything in sight. It was as if the hunger was so great that it consumed her entirely, to the point of losing all control. Once calmed down, she would eat and eat and consume many glasses of liquids. She would drink so quickly as to choke on her juice and it was as if she were so thirsty that she couldn't drink enough."

A major problem for the homeless is not only whether they receive enough food or calories but the nutritional content of the diet.

A major problem for the homeless in regards to their diets is not only whether they receive enough food or calories but the nutritional content of the diet. According to Winick (1985), a lack of certain vitamins or minerals can lead to specific deficiencies. Iron deficiency can cause anemia; poor wound healing results from a lack of Vitamin C; and B-vitamin deficiencies can affect the central nervous system. It is interesting that one of the symptoms of Vitamin B deficiency is depression, which is very common in the homeless. Zinc deficiency is often a cause for concern with poor people. Such a mineral deficiency can be particularly dangerous in pregnant women and children because zinc is essential for cell division. Zinc deficiency can have devastating consequences, including birth defects. Winick further notes that the food provided by the private non-profit organizations he visited in New York City was not nutritionally adequate, especially for children, pregnant women, and the elderly.

Hungry children are unable to concentrate in school and can't learn. Pregnant women jeopardize the well-being of their unborn children and themselves, while tiny, helpless babies are hospitalized for malnutrition. A lack of food equals poor nutrition, which, in turn, leads to sick children. Sick children can neither grow nor develop properly.

EDUCATIONAL PROGRAMS FOR CHILDREN

> One mother tried to register her children at a parochial school near the hotel where they lived but was told, "Hotel kids just won't fit in."

School-Aged Children

Concern is widespread over the attendance problems experienced by the 6,000 or more school-aged homeless children in New York City shelters and welfare hotels. By Labor Day last September, only 583 children ages 6 to 17 in 33 hotels had been registered for school (*New York Times*, September 3, 1987). In District 2 in Manhattan, where the majority of the city's homeless children attend school, only 200 students had been registered, and of those "only a few showed up the first day" (*Westsider*, September 17-23, 1987). "No one is responsible for these children," said City Councilwoman Ruth W. Messinger in a report released at the start of the school year. Compared to a citywide average of 89%, school attendance for homeless children ranges from a low of 50%, to a high of 70% (Horton, 1987).

Compared to a citywide average of 89%, school attendance for homeless children ranges from a low of 50%, to a high of 70%.

The central Board of Education itself acknowledges the seriousness of the problem. By mid-November, the Office of Student Progress, which oversees school programs for homeless children, had school records for only 3,300 children who were attending school "though not always regularly." Another 2,000 children were suspected of having "severe attendance" problems, and 700 other children had "fallen through the cracks" (*New York Times*, November 12, 1987).

Ironically, the school system itself has assumed the responsibility for being "the chief advocate in providing and coordinating services for children residing in temporary housing" (Chancellor's Regulation No. A-780, p. 1). A comprehensive array of services are to be provided to children residing in temporary housing including: wake-up calls, transportation, breakfast, lunch, dinner, extended day enrichment activities, health services, daily attendance monitoring, guidance and recreation (Chancellor's Regulation, No. A-780, p. 1). A Hotel Unit, within the Office of Student Progress, was established in 1981 to address the issues of educating homeless children, including registration and attendance problems. According to a school administrator, "each shelter that has school-age children," has assigned to it either a full-time or part-time staff person to be responsible for "monitoring families and seeing that children are registered." (B. Gross, personal communication, February 1, 1988).

Unfortunately, the system does not appear to be meeting its own mandates. Parents living in hotels say they are not receiving information about the appropriate schooling of their children in a timely or consistent fashion. The system's back-to-school registration drive was only 10 days long (August 18-28; *New York Times*, September 3, 1987), and apparently was not well publicized. According to a service provider at one of the city's largest welfare hotels:

> "None of the eligible 5-year-olds made it to kindergarten the first week of school because they were not registered. The Board's hotel office was closed all summer, it didn't open till August 7, but even then, it was not open every day and nobody knows their schedule" (interview, September 18, 1987).

One mother at this same hotel went to the nearest public school to register her child, but was told that because she lived in a hotel she couldn't register at the school directly and needed to go to the district office.

One problem may be a manifestation of an ongoing Board of Education tension---to what extent is the attendance and programming for homeless children (and many other educational issues as well) a centralized versus decentralized effort? On the one hand, the Chancellor's regulations stipulate that it should be the responsibility of the local Community School Districts to "fully coordinate services" for homeless children (A-780, p.1); yet, it is the responsibility of the Central Board to provide "citywide coordination" of services, and handle attendance and transportation. These have the potential to be competing responsibilities. In the opinion of the Board's former ombudsman for homeless children, it should be a district responsibility, since that would make it "more likely to make [other programmatic] linkages for children" (J. Blair, personal communication, February 1, 1988).

"Families don't bother enrolling their children in school because they know they'll be moving."

Existing City policy further complicates things. For example, there is an HRA policy that allows the placement of families with school-age children in short-term (i.e., only up to 28 days) hotels. "Families don't bother enrolling their children in school because they know they'll be moving" (*Daily News*, October, 1987). Even the HRA/Board of Education's attempt to match computer tapes, and thus identify homeless children in the public schools, was initially hampered by the fact that HRA only listed family members by the last name of the household head, thus eliminating hundreds of children with different surnames than their mothers. (This has now been modified; families are now asked under what names their children are registered for school.)

This gives credence to one of the Messinger report's key findings, namely, the "fragmentation of responsibility

A 1985 survey of mothers living in four New York City welfare hotels found that only 15% of the 161 children ages 0 to 5 were enrolled in an early childhood program.

and the lack of coordination between agencies working on the issue" (p. 7). In the meantime, the children are not getting to school.

Preschool-Aged Children

And what of the younger children--the children under age 5 whose numbers are larger than any other age cohort of the homeless? The developmental needs of the 5,000 or so children, birth to age 5, some of whom have lived their entire lives in a welfare hotel, are going largely unmet. Board of Education President Robert F. Wagner Jr. has proposed that there be year-round day care and preschool education for homeless children, as young as age 2 (*Newsday,* November 30, 1987). Yet, presently, homeless preschool children are apparently not a priority of any of the system's existing recruitment efforts. The New York City public schools have close to 11,000 slots for preschool-aged children through a variety of programs, most of which are targeted to the educationally or economically disadvantaged. It is not known whether homeless children are served by any of them.[1] A 1985 survey of 84 mothers living in four New York City welfare hotels found that only 15% of the 161 children ages 0 to 5 were enrolled in an early childhood program. Two-thirds of these children were two-years-old or younger; only three of them had access to child care services (Vanderbourg & Christofides, 1986).

---

[1] The New York State Experimental Prekindergarten classes targeted specifically to homeless children opened in February, 1988, one in each of two schools in Community School District 1. These are full-day classes (8:40am - 3:00pm, with an optional after-school component from 3:00pm - 6:00pm).

There can be, and often are, multiple agendas underlying programming for young children. State shelter regulations require that Tier II facilities provide supervised care of all children "when such care is necessary to enable the parent or caretaker relative of such child to seek employment and/or permanent housing or to attend school or training" (18 NYCRR 900.10). In fact, supervised child care is essential for enabling mothers to ride the HRA housing van (children aren't allowed), or for picking up their bi-monthly rent checks, or for keeping any of the other innumerable appointments that make being homeless a fulltime job. In the survey cited above, mothers were asked their most essential reasons for needing child care (of the sample of 154 mothers, 90% expressed a need for childcare). Their reasons for needing care included the following: 64% mentioned the housing van; 63%, public assistance appointments; 49%, medical appointments; 42%, job search; 38%, food stamp appointments; and 28%, shopping; plus other miscellaneous reasons. The resulting report, issued by City Councilwoman Ruth W. Messinger, made a strong case for an expansion of existing child care programs.

Supervised child care is essential for enabling mothers to ride the HRA housing van, or for picking up their bi-weekly rent checks, or for keeping any of the other innumerable appointments that make being homeless a fulltime job.

There is another purpose for child care programs beyond serving the mother and that is serving the child. There is a considerable body of research attesting to the power of early intervention in the lives of young economically-disadvantaged children (Bronfenbrenner, 1974; Consortium for Longitudinal Studies, 1983). A high quality early childhood experience not only has positive effects on a child's cognitive and socio-emotional development in the short-term, but more fundamentally, it can produce substantial positive benefits on the long-term educational and general life experiences of poor children.

The day care program directors we talked to were keenly aware of the need for and potential of early childhood programs for homeless children.

> "Our program gives children stimulation. It gives them the opportunity to continue on the developmental milestones and not stagnate. Too many homeless children stay in a holding pattern and don't develop adequately. Our program provides continuity for the child. It encourages growth." (Director of a Tier II, on-site day care program)

> "People don't talk about life in the hotels. Our program allows kids to get away from what's scary and to talk about those scary things, why they're scared; it gives them permission to be scared. Our program gives the kids another way to live that's not violent. They have to be taught to survive here but they also need to know that they don't need to be that way always. There are other ways to live." (Director of an on-site day care program at a welfare hotel)

> "The day care center is here to relieve the parents so they may go to welfare, look for housing, go to court. But the children need it to be with other children and to get out of their room." (Director of a Tier II, on-site day care program)

There are close to 1,200 day care slots available for homeless children in New York City, including 850 slots for children up to age 6, and 350 school-age slots for children age 6 to 12. (See Table 4 for the availability of early childhood programs for homeless children.) 790 of the preschool slots and all of the school-age slots are administered by the Agency for Child Development (ACD) and so are in licensed, predominantly all-day, all-year programs. The majority of the slots are in ACD day care programs; about 200 are in ACD Head Start centers. Money is now being made available for 60-80 new

Table 4

Early Childhood Programs for Homeless Children

ON-SITE PROGRAMS

Sponsor	Site	Funding	Slots
Manhattan			
American Red Cross	Emergency Family Center	ACD*	48 preschool
Association to Benefit Children	Hotel Martinique	ACD*	40 preschool
	East Harlem Family Center	ACD	14 preschool
Children's Aid Society	Prince George Hotel	ACD*	66 preschool 30 infants
Jewish Board of Children and Family Services	Hotel Regent	ACD*	30 preschool
Boys Harbor	Harriet Tubman Day Care Center	ACD*	40 preschool
Henry Street Settlement	Urban Family Center	ACD (voucher)	15 preschool
Bronx			
Homes for the Homeless	Prospect Interfaith Family Inn	ACD*	20 preschool
Queens			
Homes for the Homeless	Saratoga Interfaith Family Inn	ACD*	35 preschool
Brooklyn			
Colony South Brooklyn Houses	Amboy Street Day Care Center	ACD*	55 preschool

Table 4 (Cont'd.)

OFF-SITE PROGRAMS

Sponsor/Site	Hotels Served	Funding	Slots
Manhattan			
Association to Benefit Children/ All Children's House	Allerton Hotel, Allerton Annex	Non-ACD	30 preschool
Bethlehem Day Nursery	Roger Williams, Marquis, Latham, & Prince George Hotels	ACD	10-15 preschool
Boys Harbor	Regent Hotel, Hamilton Hotel, Convent Avenue Shelter	ACD*	55 preschool 100 school-age
DeWitt Head Start	Martinique, Madison Latham, Carter, Marquis, Deanville & Prince George Hotels	ACD Head Start*	100 preschool (full-day)
Educare Early Childhood Centers	Prince George	ACD	5 preschool
Hudson Guild	Allerton Hotel, Allerton Annex	ACD Head Start** ACD	15 preschool (full-day) 11 preschool
Nazareth Day Nursery	Hotel Martinque	Non-ACD	15 preschool
Plaza Head Start	Carter & Holland Hotels	ACD Head Start	9 preschool (half-day)
Polly Dodge	Holland Hotel, Bryant Hotel	ACD*	20 preschool
Police Athletic League/ Duncan Center	Holland Hotel Hotel Martinique, Emergency Family Center	ACD*	140 school-age
Women In Need (WIN)/ Kid's Care	WIN Shelters	Non-ACD	10 preschool
PRACA 3	Martinique Hotel	ACD*	34 preschool

Table 4 (cont'd.)

OFF-SITE PROGRAMS (Cont'd.)

Sponsor/Site	Hotels Served	Funding	Slots
Bronx			
Police Athletic League/ Lynch Center	Fox St. Shelter Prospect Hotel Prospect Interfaith Family Inn	ACD*	90 school-age
Brooklyn			
Colony-South Brooklyn Houses/ Nat Turner	Brooklyn Arms Hotel	ACD*	40 preschool 20 school-age
Bedford-Stuyvesant Head Start	Brooklyn Arms	ACD Head Start*	40 preschool (full-day)
Queens			
Better Community Life	Travelers Hotel	ACD*	20 preschool

---

* ACD slots targeted to homeless children.

** There are approximately 60 children in Head Start slots not especially targeted for homeless children.

Sources:

ACD targeted slots (sites and number of slots per sites): Pat Douglas, ACD, January 25, 1988; Judy Perry, ACD Head Start, January 29, 1988.

Other program sites: Toni Porter & Annice Alt, Child Care, Inc., July, 1987, February, 1988.

Feeder hotels/shelters for off-site programs: interviews with program directors.

slots. Unfortunately the need is much greater. The Prince George Hotel, for example, has 457 families, most of whom have at least one preschool-aged child; the 66 on-site half-day slots may not even meet 10% of the need. The Hotel Martinique, with 421 families, has 35 preschool slots. Systemwide, only 15% of homeless children birth to age 5 are enrolled in early childhood programs. Worse, only 30 infants are known to be served (and this through a once or twice a week "home-based" infant stimulation/parent education program); yet children under the age of three may comprise two-thirds of homeless children below school-age (Vanderbourg & Christofides, 1986).

The Hotel Martinique, with 421 families, has 35 preschool slots.

Systemwide, only 15% of homeless children birth to age 5 are enrolled in early childhood programs.

Who is served? Anecdotal accounts suggest that "the family that takes advantage of one service takes advantage of all the services" (interview, September 18, 1987), implying that many children and families have nothing. Day care directors admit that "many are not served." Some families "choose not to get involved; they choose not to leave their rooms in order to protect their children. They are coping this way," said the director of an on-site day care program at one of the welfare hotels. Said the director of an on-site program at a Tier II shelter, "There are 60 eligible children living here, but we have no waiting list [for a program that can accommodate 15 children]. Isn't that sad? They won't even register."

Only 30 infants are known to be served by preschool programs; yet, children under the age of 3 may comprise two-thirds of homeless children below school-age.

And once enrolled, it is difficult to maintain attendance. This is true for on-site as well as off-site programs. In fact, the highest attendance rate among programs we visited was in an off-site program.

> "Out of 55 children, 40 is high [attendance]."
> (Director of an on-site, Tier II program)

> "Today in a class of 15, 6 arrived on their own; we recruited 3 others." (Director of an on-site, Tier II program)

> "With tremendous outreach [e.g., knocking on doors], 60-70% attendance is good." (Director of an on-site hotel program)

> "Our attendance is good because we provide transportation and pick-up at the hotel. Our attendance rate is around 75% but there have been weeks with 100% attendance." (Director of an off-site program)

Why don't children come? Illness, fatigue, fear, lack of motivation---all contribute to low attendance.

> "We have a problem with hotel children. Problems such as no hot water in the hotel are common. Parents will not send their children because they are dirty or have no clean clothes. There is a lot of asthma, especially in winter." (Director of an off-site program)

> "It's hard to make sure all the children get physicals so they can enroll. Mothers have immediate needs like getting out of the hotel, and getting a medical exam does not take priority." (Director of an off-site program)

> "There's too much going on. There's lots of commotion, children running around, drug deals, gangs. Children don't get enough sleep, they're ill, they have no clean clothes." (Director of an on-site hotel program)

> "Not all parents will send their children here. Why? They have to wake up in the morning, they'll be more visible...Some parents are day care phobic. They fear the child will be abused. Some just won't be kept to a routine; they go out late, they sleep late." (Director of an on-site Tier II program)

The State's shelter regulations essentially allow for unlicensed day care in Tier I and Tier II shelters.

And, too often, it is the child who suffers. "It's very confusing and bewildering to the child. It's more disruption in an already chaotic environment," said one director.

A Two-Tiered System? The implications for children are further complicated by the New York State Department of Social Services (DSS), which has created an artificial distinction between what it is calling "child care" for homeless children (as required in 18 NYCRR 900.10) and what is traditionally meant by "day care" in a regulatory sense. New York City has among the strongest day care standards in the country. The regulations, as promulgated by the City's Board of Health (Article 47 of the Health Code), specify space requirements, group size, and staff qualifications, as well as minimum standards for features of the physical plant. The State's shelter regulations, however, essentially allow for unlicensed day care in Tier I and Tier II shelters. There are neither physical space nor staffing requirements.

Whereas fire marshals and building inspectors may be most disturbed by the absence of safety precautions, early childhood educators are most concerned by the disregard for programmatic consideration, especially staff qualifications. Professional standards in the field stress the importance of appropriately trained staff with "college-level specialized preparation in early childhood/child development" (Bredekamp, 1986, p. 14). Yet, according to the shelter regulations, "a suitable adult resident may be counted as staff for the purposes of the supervised care ratio" (Part 900.10 [5] [ii]). Granted, the regulations stipulate that all staff "must have prior experience in child care or must receive adequate training," but nowhere is "adequate" defined.

To create a two-tiered system seems inequitable and could have unintended negative consequences for children.

This action has been justified on the grounds that the goal of the Part 900 shelter regulations was to provide "drop-in" care for residents' children while the parents attended to various business; it was not to provide "regular/daily" day care (J. Semidei, written communication to A. Alt [Child Care, Inc.], June 23, 1987). We are in full agreement that day care options, including a mix of drop-in and all-day program, are essential. However, the net effect in this instance is the creation of a double standard with the most vulnerable children potentially receiving the most inadequate care. While it is important to recognize the need to loosen up some of the rigidities of the existing New York City Health Code and facilitate the access of day care/child care services to larger numbers of children, to create a two-tiered system seems inequitable and could have unintended negative consequences for children.

It is clear from the regulations that the purpose of the requirement for child care is purely custodial (i.e., to enable the parent to look for housing or employment). But if the child's best interests are also to be considered, then much more is required. As one observer of an on-site program for homeless children described it:

> "If anything, you need more highly trained staff, almost like in a therapeutic nursery, ...[but] what you're getting is good hearts, with little experience" (interview, January 29, 1988).

P.L. 99-457. The mandate of P.L. 94-142, the Education of All Handicapped Children Act, was extended to developmentally disabled preschoolers with the passage of P.L. 99-457 in 1986. States are now mandated to serve 3- to 5-year-olds by 1990. (Services for children birth to age 2 are optional). Although data are scarce (see the later section on the developmental impact of homelessness on young children), there are potentially many New York City children who would be eligible for services under this Act. Presently, in New York City, however, there is no outreach effort or "Child Find" until school-age (4 years, 7 months up to age 21). Prior to that, it must be the parent or other family advocate who takes the initiative.

States have the option of whether or not to include "environmental risk" among their eligibility categories. New York State does not. Part 200 of the New York Education Department Regulations specifies those categories which determine eligibility for services under P.L. 99-457 in New York State:

- Autistic
- Emotionally disturbed
- Learning disabled
- Mentally retarded
- Deaf
- Hard of hearing
- Speech impaired
- Visually impaired
- Orthopedically impaired
- Multiply handicapped

Because P.L. 99-457 mandates an individualized *family* services plan along with direct services to the child, it is essential that its implications for New York's homeless be explored.

CHILD AND FAMILY WELFARE

> "How do you work with a young mother with so many stresses in her life? You can't put her into housing before she's ready. She needs life skills, job skills. They need to learn their strengths so they can get off welfare." (Director of a Tier II shelter)

With a caseload of 60 families in constant crisis, CIS caseworkers barely have time to "slip a note under people's doors once a month." The vast majority of homeless New York families have little access to the kinds of intensive help that would enable them to enhance their skills in coping with the unrelenting demands of poverty and parenting especially in the absence of stable housing. Of particular concern is the absence of any proactive attention to the mental health and other emotional needs of the children, and the parents as well. Of course, not all homeless families need supplementary support services. Many just need housing. Indeed as noted earlier, systemwide in New York City, half of homeless families are re-housed within five months. But half are not. Those families tend to be long-term stayers in the shelter system. They are the families who may, at the outset, have other needs and thus require the most support in accessing services.

Half of homeless families are re-housed within five months. But half are not. Those families tend to be long-term stayers in the shelter system.

The Mental Health Status of Homeless Families

The results of clinical interviews with 80 homeless mothers living in 14 family shelters in Massachusetts are troubling in what they tell us about the mental health status of homeless families. Using classifications from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the American Psychiatric Association; 1980, 27% of the group were assigned DSM-III Axis-I diagnoses indicating the

"Parents need nurturing, too. This is the number one problem."

presence of major psychiatric syndromes (e.g., major affective disorders [10%], substance abuse [9%], mental retardation [5%], schizophrenia [3%]). Almost three-quarters (71% compared to 15-20% in the "normal" population at large) were given Axis-II diagnoses of personality disorders (e.g., dependent, passive agressive, antisocial); nine mothers received diagnoses in both sets of categories. Only 11 mothers (14%) had no DSM-III diagnosis (Bassuk, Rubin, & Lauriat, 1986).

Perhaps their mental health status is related to these mothers' weak networks of social support. When asked, "What people could you turn to in a time of stress?", 26% could name no one. Thirty percent could only name one person; 26% mentioned a minor child. But what comes first: a dissolution of social support or emotional stress? Is it really any surprise that families living in anxiety and uncertainty, and often fear, without even the security of their physical belongings should feel depressed---or antisocial---or passive and dependent (i.e., defeated)? "Parents need nurturing, too. This is the number one problem," we were told by the director of a day care program for homeless children. "These [Axis-II] families don't need psychotherapy; they need social welfare services" (E. Bassuk, remarks made at the New York University Urban Research Center, April 3, 1987).

Access to and Eligibility for Services

But are families getting the services they need? The problem of overworked caseworkers is compounded by the absence of outreach. Families aren't actively seeking services. "There's a stigma to seeking mental health services; they feel singled out, wary and scared," a caseworker told us. "The important elements of casework--

the relationship, the caring---some of these people have never had anyone care about them, so initially they see it as an intrusion," said the director of a Tier II facility. Fear of the system is another reason. "Fifteen percent of our clients have open SSC cases. Building a bond with the mother is difficult. They are often in situations where they don't trust anyone. If they say the wrong thing, they could lose their child." This is apparently not an irrational fear. We heard far too many anecdotes from teachers about mothers leaving their children with a neighbor down the hall so they could go do an errand (in one case a mother was at a hospital overnight receiving emergency medical care), the neighbor tiring of the child(ren), contacting a caseworker who contacted SSC, and the mother returning to find her children gone, removed to foster care.

"Building a bond with the mother is difficult. They are often in situations where they don't trust anyone. If they say the wrong thing, they could lose their child."

Are children at risk of imminent removal and placement into foster care just by virtue of living in a welfare hotel or other shelter? If a child eats lead paint, or falls out of an unstable crib, or isn't kept clean because there is no water, is that neglect and if it is, whose fault is it? The mother's? In situations where frustrations are high and opportunities for releasing stress are low, and tempers get out of hand, whose fault is it? The child's? We need to be concerned about the relationship between homelessness and foster care placement. In New Jersey, 25% of children in foster care are children of the homeless (Zelkind, 1988).

In New Jersey, 25% of children in foster care are children of the homeless.

Comparable data do not exist for New York, but there are many who believe that if not actually at "imminent" risk of foster care placement, homeless children are "at-risk" in a more general sense and deserving of special preventive services. With respect to voluntary foster care placement (e.g., a homeless mother choosing to place her children in foster care), the Legal Aid Society has argued (*Cosentino v. Perales*, Index No. 43236/85; *Martin & Bill A. v. Gross,* Index No. 24388/85) that inducing homeless or inadequately sheltered families to place or keep their children in foster care because of inadequate or non-existent shelter violated provisions of the State's Child Welfare Reform Act (CWRA). The CWRA mandates that preventive services (supportive and rehabilitative) be provided when it's determined that a child will be placed in foster care if such services are not provided or that a child already in foster care can be returned home if such services are provided. Legal Aid challenged the State's and City's failure to provide preventive services in the form of emergency shelter and other housing services. (The City and State are presently appealing the Court's order to provide such preventive services.)

It would seem that homeless families in emergency shelters should also be eligible for preventive services in the form of certain core services defined by State statutes as including: day care, homemaker services, parent training, transportation, clinical services, and 24-hour access to emergency services such as shelter, cash, and food (18 NYCRR Sec. 423.4 [d]), and certainly, at minimum, to case management, case planning, and casework contacts.

Given its limited resources, SSC would seem to agree in principle. Currently, SSC supports two preventive services programs for homeless families. Each serves about 80 hotel families over the course of a year (40 at any given time). Women in Need's STOP (Services to Prevent Placement) program serves families from hotels in the Times Square area, as well as families in Women in Need's own Tier II shelters. Essentially, the program does case management (helps families find housing, straightens out their benefits, gets children to school, etc.); it also runs parent support groups. The Angel Guardian Family Support Center works with families from the Brooklyn Arms Hotel in much the same way (e.g., doing case management, counseling, information referral and advocacy, recreation, teaching of home management skills).

Support falls far short of the need, however. "We get more referrals than we can handle," says Women in Need's Bonnie Strahs. "Just about any family is at-risk for placement, just by being there" says Andy Lagnese of Angel Guardian's program about the 265 families at the Brooklyn Arms. Although there have recently been some new State and City preventive services funds made available, they are being shared among five target groups (homeless children, boarder babies, abuse and neglect cases, PINS [Persons in Need of Supervision] children and foster care discharge cases) and only about 48 new homeless families will be served by these funds. If we can make a difference in the lives of some homeless families, why not all?

A SPECIAL LOOK AT PRESCHOOLERS

There is a paucity of systematic data that focuses on the cognitive and socio-emotional development of homeless children.

Of the 10,945 children in City shelters this most recent Thanksgiving Day, half were younger than 5 years old. Prior sections have examined what we know about how well the basic needs of homeless children are being met. In this section, we highlight aspects of the developmental profile of young homeless children. How are they doing *as children*? Will they be ready for the social and intellectual demands of the larger world of school and society a few short years down the road? For many children, it's too early to tell. For others, without intensive intervention, the future's cards seem already to have been dealt.

Unfortunately, there is a paucity of systematic data that focuses on the cognitive and socio-emotional development of homeless children. The little there is is troubling. Dr. Ellen Bassuk, a psychiatrist at Harvard University, found that within a sample of 156 homeless children in 14 Boston shelters, one-half of the school-aged children showed signs of clinical depression and anxiety, 43% were failing or performing below average, 25% were in special education, and 43% had already repeated a grade (Bassuk & Rubin, 1987). Among the 81 children under age 6, close to half (47%) exhibited at least one serious impairment in language, social skills, or motor development as measured by the Denver Developmental Screening Test, an instrument utilized by pediatricians to identify gross developmental delays. Bassuk & Gallagher (n.d.) describe one pair of siblings:

> "Five month old Sarah is a frail looking, listless child, who has moved four times since her birth. She weighs only 10 lbs. 10 oz. and is being followed closely by a family doctor because of a serious feeding problem. Mother says she "spits up and can't hold milk

> down." On the Denver, she lagged in all areas tested. She was unable to grasp a rattle and rarely vocalized or smiled. Her 16 month old brother, who had moved seven times since his birth, was a shy withdrawn, quiet child. On arrival at the shelter, he stopped saying the few words he knew, refused to eat, and had trouble sleeping. He also failed in the four major areas tested on the Denver." (pp. 5-6)

Equally disturbing was a comparison of general behaviors of the homeless preschoolers ages 3 to 5 with samples of "normal" and emotionally disturbed children using the Simmons Behavior Checklist (a 27-item rating scale which was completed by the mothers). Mothers of homeless children reported a higher incidence of the following behaviors than mothers of "normal" children: attention problems, sleep problems, shyness, speech delay, dependency, toilet training problems, withdrawal, demanding behavior, aggression, and coordination problems. The only behavior which was reported more frequently for the "normal" children was fear of new things. There were a number of similarities between the homeless children and the emotionally disturbed sample regarding toilet training, withdrawal, and demanding behaviors. Homeless children, however, were reported by their mothers to have more sleep problems, and to be shyer and more aggressive than the emotionally disturbed sample.

Observational Data

These data are reinforced by our own observations and by teachers' anecdotal accounts. Our observations have several sources. We observed 14 different early childhood programs including eight on-site programs and six off-site programs. In order to get a sense of developmental change over time, over the course of six months, we made weekly visits to an on-site Tier II day care program. In addition, one of our staff worked part-time at an off-site day care program targeted to homeless children.

Mentioned by teachers and observed most frequently were the following types of behaviors (since group programs for homeless children are almost exclusively for preschoolers, these accounts pertain primarily to children aged 2 1/2 to 5 years):

Short attention spans/weak impulse control---restlessness, difficulty sitting still and focusing on an activity without constant one-to-one attention from an adult. Child seeks attention through testing or "acting out" behaviors, or more directly, by actively trying to maintain physical contact with the adult (e.g., pulling on earrings, sitting on lap, holding hands).

Withdrawal---isolated from the group, flat emotion, minimal verbalizations, self-stimulatory activity (thumb sucking, hair twirling).

Aggression---low threshold for frustration, quick to overreact, active initiation of intrusive behavior.

Speech delays---little expressive language, garbled speech, slurred words, difficult to understand.

Sleep disorders---sobbing, crying out in sleep; afraid to fall asleep, difficulty waking up.

"Regressive"/toddler-like behaviors---thumb sucking, piling and stacking of toys, putting toys in mouth, hoarding food.

Inappropriate social interaction with adults---*with strangers*: lack of inhibitions; warm greetings, lots of touching, hugging, kissing, even at first introduction. *With mothers*: cool, detached interactions, little eye contact, often no good-bye at drop-off, no greeting at pick-up, little physical contact.

Immature peer interaction contrasted with strong sibling relationships---*with peers:* inability to share, to take the perspective of another, easily frustrated. *With siblings*: protective, empathetic; evidence of strong bonding.

89

Immature large motor behavior---especially evident in a clumsy stride and awkwardness when running.

These generalizations, while obviously not true in all cases, came from observing and hearing about children like Valerie, Daniel and Rosa (these are real children, though their names have been changed).

VALERIE is 3 1/2 years old. A heroin withdrawal baby, her language is extremely delayed and difficult to understand. She has trouble with certain initial consonants. Her conversation primarily consists of single-word utterances. "Cookie, duice" (for juice). "Ight, ight." (for light). "Look. Book." (Valerie's brother, at 18 months, is still not walking).

DANIEL who is 3 years, 7 months and still in diapers, cries out in his sleep. He is difficult to awaken, screaming and fighting and crying when roused. Daniel is in day care because of an SSC mandate. His mother did not want him in the program. His eye contact with others is minimal. He ignores his mother when she comes to get him. She will sometimes pull him by the ear to get him to leave.

ROSA is 3 1/2 years old. Her expression is blank and she never smiles. She watches people carefully, often staring into their eyes as if they are addressing her. She is silent for the most part except when, for no apparent reason, she begins sobbing. She sits quietly sobbing, pulling on her barrettes.

Food. The primacy of food is an aspect of child behavior that deserves special attention. Food issues were much more prominant among the homeless children whom we observed than in most groups of preschool children. Food figured prominently in children's play, especially dramatic play and art. When creating objects out of clay, for example, children almost exclusively made "food." Food (real food) was jealously hoarded at mealtimes. A few children ate nothing at mealtimes; most ate everything on their plates---and seconds, and thirds. One observer reported her shock at seeing "a large group of preschoolers sit quietly at the table and without complaint eat all the food that is placed in front of them." For more advantaged childen, eating problems and fussiness about food are viewed as part of the power struggles that children typically have with their parents or other adults. Children who *need* to eat find other vehicles for asserting their sense of self (see below).

For hungry children, food has a much higher priority than games or songs.

> We tried to engage Lisa in play. She was sitting at a table with two other children who were playing with puzzles. She didn't say a word, but just sat quietly with her hands at her sides. In an effort to engage her, we asked if she wanted to play with a puzzle. She said no. Well, how about a story? No. A number of other suggestions were made. Lisa shook her head to all of them. "You don't want to play with anything?" "No, I want food." (Bank Street observer)

When asked what they liked most about a summer preschool program, a group of 4- to 5-year-olds enthusiastically responded, "Snack! Rest!"

When asked what they liked most about a summer preschool program, a group of 4- to 5-year-olds enthusiastically responded, "Snack! Rest!"

Children's Strengths

Children's strengths and the adaptability of their coping strategies are easily masked by behaviors traditionally

Children's strengths and the adaptability of their coping strategies are easily masked by behaviors traditionally considered "inappropriate" in an early childhood setting.

considered "inappropriate" in an early childhood setting. However, what may be judged as "inappropriate" behavior may, in fact, be quite appropriate once the context of the behavior is better understood. For example, the physical activity and running around that is frequently characterized as hyperactive may be quite an appropriate antidote to a small, cramped and crowded room. The awkward gross motor movements we observed should not be surprising among a group of children who, as infants and toddlers, are either held or confined to a stroller. A roaming toddler demands boundless energy and attention from adults. In most shelters, the halls are unsafe, the floor is dirty, and a small room cramps free movement. The safest and clearest choice for the mother is to prohibit the child's movement. Unfortunately, practicality of the short-term solution can lead to impaired psychomotor development later on.

Homeless children are often labelled "delayed" when the context for their behavior is not understood.

Another feature of children's "running around" behavior is the limit testing that often accompanies it.

> "Tony's response when asked to do something is to run. If I take him aside and sit him down, he has a big grin on his face and one foot outstretched ready to go." (Day care teacher)

However, instead of being a sign of dysfunctional behavior, some providers have observed that it is once children begin to feel secure enough within the environment that they begin to test how far they can go. An important part of the testing/acting out behavior is the question, "How much is the teacher going to protect me?" Once these control issues are resolved, program directors have noted that children are then able to interact in ways and with skills that are more appropriate for their age and level of development. Thus, homeless children are often labelled "delayed" when the context for their behavior is not understood.

Many poor children are unfamiliar with toys. More fundamentally, they lack knowledge of age-appropriate concepts like colors or shapes.

An element of behavior frequently observed in clinical settings, is the inappropriate anger and frustration displayed toward peers. This negative group behavior may actually be the enactment of positive coping strategies. Sometimes it is the only way the children know how to make contact. For many of these children, the frustrations of their living situations produce considerable anxiety. Research suggests that negative interaction, while not the best way to make friends, is healthier than internalizing anger which, in extreme instances can lead to physical self-abuse (e.g., children hitting their own heads).

Assessment Issues

To maximize effectiveness of the short time that they have with some of the homeless children whom they serve, teachers and directors spoke to us of the desire for a screening tool, or some way to assess the child's developmental status, and then enable them to appropriately meet the child's needs. There are obvious problems with some of the tools currently used. One key issue is the extent to which traditional assessment batteries assume prior exposure to the many toys and trappings of a middle-class childhood. Many poor children are unfamiliar with toys. They don't know what to do with crayons; they need to be "taught" how to do puzzles. More fundamentally, they lack knowledge of age-appropriate concepts like colors or shapes. Beyond not knowing specific shapes, or colors, many children do not seem to know to what property of an object "color" or "shape" refers. Is this deficit the result of impaired cognitive functioning (i.e., a lack of cognitive capacity) or, more simply (and more probably) does it reflect the lack of relevance of these concepts in the child's everyday world? "It's not the intellect. It's not the I.Q. It's that they're not exposed. They're not like a typical 3-year-old," said one day care director in frustration.

At present, most measurements of child development are static, overly focused on the cognitive domain, and removed from the child's daily context of development.

Disentangling ability/capacity issues from exposure is a complex and difficult process. However, to overrely on standardized measures that ignore cognitive processes is to project additional deficits onto a group of children suspected of experiencing considerable development lags already, and to ignore potential strengths. Although their skills in interacting with peers need polishing, for example, homeless children evidence a keen ability to read adult behavior. "They search your face to see if you're really being straight with them," said one day care director.

At present, most measurements of child development are static, overly focused on the cognitive domain, and removed from the child's daily context of development, thus overlooking many of the child's strengths. Furthermore, they are not easily incorporated into a program provider's ongoing process of needs assessment. Thus, they have limited usefulness in the design of appropriate interventions for children.

The Impact of Inadequate Family Supports on Child Development

Children's developmental status must also be considered within the context of available supports for the family unit as a whole. More important than overall trends are the extraordinary cases of resiliency and coping---frequently seen as evidence of what a quality early childhood program can accomplish---and, at the other extreme, the cases of

Depression in parents may have particularly negative consequences for children, more so even than other forms of mental illness.

deterioration over time---evidence of what can happen when the family's needs as a unit are not met.

> "After being here awhile a mother gets very angry and depressed. The child mirrors the mother's stress; the child's behavior reflects the mother. It's not clear that the behaviors a child exhibits are related to homelessness per se, but to the mother's state," said the director of an on-site Tier II program.

This observation is consistent with recent research evidence which suggests that depression in parents may have particularly negative consequences for children, more so even than other forms of mental illness (Lyons-Ruth, Botein, & Grunebaum, 1984). Young children, especially toddlers, may be particularly vulnerable because parental depression, with its attendant psychological unavailability, appears to be more disruptive at the stage of development when children normally use their secure relationship to the parent as a base from which to explore the environment (Cicchetti & Aber, 1986).

WANDA'S mother is severely depressed. She rarely leaves her room and just lays in bed or sits and stares. She complained about having to get Wanda dressed for day care, and for a few days didn't send her at all. Her youngest child, an infant, was removed from her at birth and placed in foster care.

When not at day care, 3-year-old Wanda is usually left unsupervised and is not fed. She is often sick and dirty. Teachers wash her when she arrives. Teachers believe that she is sick so often partly because she eats things off the ground---she eats dirt, sucks on her shoes, licks outdoor toys. One teacher doesn't think she's grown at all in the 14 months that she's been in this particular shelter. At three years of age, she still uses a pacifier and wears diapers. Wanda calls all female adults "Mommy," but addresses her mother by her first name. When her mother arrives to pick her up at the end of the day, Wanda's response is ambivalent. Sometimes she ignores her mother, sometimes she runs to her; occasionally, she'll throw a tantrum and refuse to leave the center.

In spite of all this, Wanda is a child who challenges the odds. She is spunky, talkative, personable. She easily switches from Spanish to English when interacting with non-Spanish speaking adults. She can play alone for extended periods building complicated structures with Legos, playing in the sandbox, looking at books. She enjoys singing and fingerplays. Her social interaction skills with peers are among the most competent that we observed. She approaches children to play with them, to help them, to comfort them if they're unhappy. A natural leader, she often initiates activities. She is also independent, not easily frustrated, and can negotiate many self-care tasks without help. She is a child who has flowered in a supportive, developmental day care program.

MICHAEL, age 3, has also thrived in day care. His mother is deaf and uses sign language. She cannot read or write. When Michael started the program, his speech was minimal and he primarily used sign language to communicate. In two months time, his language skills have improved greatly. Although he is difficult to understand and frequently resorts to pushing, pulling, and hitting to make his point, his vocabulary is growing as he experiments with words and linguistic constructions. He and his mother have what appears to be a loving relationship. He is always happy to see her and she him.

LATICIA is not so lucky. Exactly the same age as Wanda, Laticia is one of five children. Her two older siblings are in foster care. Laticia has been in this shelter for a year with her mother, 18-month-old sister, and newborn brother. Over the past five months, a distinct deterioration in Laticia's behavior has been observed. This deterioration has been parallel with a growing drug dependency on the part of her mother.

When we first met Laticia, she was a happy, talkative child. However, her attention span was short and she was easily frustrated and dependent upon adults for help and attention. But, overall, she was a well-functioning child.

Changes in Laticia's behavior were subtle at first, e.g., more frequent thumb sucking. Things changed more dramatically after Laticia's mother fell ill one weekend and required hospitalization. She was unable to make arrangements for care of the children so she brought them to a Crisis Center. Laticia's mother was released from the hospital two days later, but apparently the Crisis Center would not release her children because she was an open SSC case. They were finally released on the grounds that she would enroll in a drug rehabilitation program for three months. Upon Laticia's return to day care, she sucked her thumb throughout the day. She stopped eating at the center, and the teachers were not sure whether her mother was feeding her. Previously, according to the teachers, "you couldn't feed her enough." Yet she still showed interest in day care activities and could be affectionate, even cheery.

The weeks passed, and Laticia's mother did not enroll in the drug program. Laticia became quieter and more withdrawn; no more smiles or hugs. She became more passive. If a child hit her, she did not hit back, she just stood and cried. She began to lose weight and became ill more frequently, chicken pox one week, eczema two weeks later. Her expression was somber, her mood subdued.

Child-targeted programs, alone, aren't enough when a family is in need of intensive intervention.

Then, one day Laticia was gone. Her mother, three months after promising to go into the drug program, went out one afternoon, and left the children with a neighbor. When, after three days, she had not returned, the neighbor called SSC and they came and took the children. The teachers never learned what happened.

All the day care in the world would not make up for the other service gaps experienced by this family. Except with exceptional children, like Wanda, child-targeted programs, *alone*, are not enough when a family is in need of intensive intervention. Parents need support and nurturing. But we did not see that important piece developed adequately in any of the programs we visited.

Parting Snapshot

Our focused look at preschoolers revealed several complex layers of behavior. When visitors first enter an early childhood program for homeless children, what they see are "just kids." However, following the initial introduction, subtle differences in the children, as compared to more advantaged children, become apparent, even striking---their uninhibited approach to strangers contrasted with their casual disregard for their mothers; their intense response to eating and sleeping activities; the very high energy level of some children contrasted to the passive, withdrawn demeanor of others; even the size of many children is different (smaller).

For purposes of developing appropriate service plans for supporting children's growth and development, we need to go beyond anecdote and informed observation for a fuller understanding of the impact of homelessness on children. Are observed developmental lags the result of a chronic life of poverty, or do the stresses, chaos and environmental conditions of homelessness make their own contribution? Does homelessness produce long-term effects on development? Answers to these questions have important policy implications that must be addressed. Given the sporadic attendance and frequent turnover of young homeless children in early childhood programs, there is also a need to develop a strategy to be used by program providers for constructing an overall profile of child development, thus allowing them to more appropriately individualize the program to the child's own strengths.

As politicians argue over politically feasible solutions to homelessness, and as advocates and others fear its institutionalization, young children are living their lives.

ISSUES AND CHALLENGES FOR THE FUTURE

> "[The shelter system] is like blindfolding people and pointing them toward the edge of a cliff with the ambulance parked and waiting at the bottom. What we the advocates, service providers, and other professionals need to do, is drive the ambulance up to the top of that cliff and meet them before they walk off the edge." (T. Russo, remarks to the National Center for Clinical Infant Programs, December 4, 1987)

The shelter system, as it currently evolved in New York City, is the result of a lack of leadership and a haphazard approach to program design and service delivery. The system was not planned. It was not designed to exploit opportunities for intensive service delivery to a vulnerable population. In fact, the shelter system meant to discourage people from seeking access to it. The result: a chaotic, chronic-crisis approach to emergency transitional (averaging 13 months) housing. The result: a system that shelters the majority of homeless families in commercial hotels.

This section opens with a quick snapshot of the kinds of places where we shelter homeless families in New York City. Challenges to effective service delivery are then highlighted. The section concludes with a summary of issues that must be seriously addressed if homeless children and their families are to be effectively supported.

The Setting: Its Influences on Parents and Children

Setting is known to exert a powerful influence on behavior. The majority of New York City's homeless children and their families are sheltered in 57 welfare hotels. On

Thanksgiving Day 1987, 29% of the City's homeless families lived in seven hotels. What were they like?

Brooklyn Arms Hotel---Brooklyn (265 families on 11/26/87; at least 556 children, 278 under age 5).

> In August 1987, 21 people were treated for smoke inhalation after a mattress was set on fire; residents reported hearing no alarm.
>
> Four children died in a fire in July, 1986.
>
> Two children fell to their deaths in an elevator shaft in 1984. (*New York Times*, August 12, 1987)

Hamilton Place Hotel---Manhattan (109 families in 11/26/87; at least 220 children, 110 under age 5).

> Fire injured 29 residents and left 6 families without shelter in October 1987. One family was quoted as saying, "Tonight we'll sleep in the subway. [It's] better than going back into a firehouse or a shelter." (*New York Times*, October 2, 1987)
>
> "The culture of the hotels is one of drugs and alcohol. It appears often to be the only answer to the despair they feel. And until there are concrete things that can be offered them---like better housing and having their basic needs met...drugs will continue to be the answer." (Off-site program provider serving children at the Hamilton Hotel)

Holland Hotel---Manhattan (169 families on 11/26/87; at least 355 children, 180 under age 5).

> In March 1986, the hotel was banned from taking new families because of 1,100 City housing, health, and building code violations, but it resumed taking families because of overcrowding in other facilities. It was banned a second time in May 1987, again because of more than 1,000 violations. Yet, in August, HRA began to send families there again because "it was the only recourse possible." (*Daily News,* August 19, 1987)

Hotel Martinique---Manhattan (421 families on 11/26/87; at least 900 children, 450 under age 5).

> "The hallways are painted a light beige color. They are dirty and smeared with grime. Dust and dirt collect on the wire mesh in the stairwells. The rooms are small and dark. They are crowded with

people and cluttered with things. Laundry hangs from the bunk beds. Some of the doors don't have locks and are propped open with shoes." (Volunteer delivering turkeys before Christmas)

"There's lots of commotion, children running around, gangs, drug deals, 50 rooms on a floor and dead ends---it's an intimidating environment." (On-site program provider at the Hotel Martinique)

In February, 1987 a guard was fatally shot.

Mayfair Hotel---Manhattan (15 families on 11/26/87; at least 32 children, 16 under age 5).

The City stopped referring families to the hotel in fall, 1987. In November, the City stopped paying rent ($67/night) for the families living there in an effort to force the hotel to correct health and safety violations. Families live in rooms infested with vermin and with peeling paint containing dangerous amounts of lead. (*New York Times*, December 12, 1987)

Prince George Hotel---Manhattan (457 families on 11/26/87; at least 1,000 children; 500 under age 5).

Records of the 13th Precinct show that between March 1986 and March 1987, in the four-block area surrounding the Prince George, there was a dramatic increase in reported serious crimes: robbery increased 427%, felony assaults went up 900% and burglery increased 57%. (*Our Town*, March 1, 1987)

"Guards have keys to the rooms; they will open rooms and help themselves to what they want."

"There is a strong drug culture in the hotel. Some families choose to stay in their rooms and never leave as a way to protect themselves and their families---this is not necessarily negative." (On-site program provider at the Prince George Hotel)

Terminal Hotel---Manhattan (37 families on 11/26/87; at least 80 children, 40 under age 5; now closed).

The state barred the City from referring families to the hotel in mid-January because the hotel failed to meet minimum living conditions. Rooms were infested with rodents. "Approximately 100 people share three toilets," and the peeling paint was found to have lead concentrations much higher than allowed by law. One family only had two beds

> and a cot for one adult and five children. (*New York Times*, January 14, 1988)

"There is much more violence from the families who come here from the hotels. They've learned to survive in the welfare hotel and violence is part of that survival," a Tier II provider observed.

In 1987, 150 families complained to State DSS of conditions similar to those found in the Terminal Hotel. In most cases the City merely moved the families who complained. What kind of support is it to place already-stressed families in a setting that would strain to the limit the personal resources of the most well-functioning families? "There is much more violence from the families who come here from the hotels. They've learned to survive in the welfare hotel and violence is part of that survival," a Tier II provider observed. Violence, fighting, and carrying weapons are grounds for involuntary discharge from non-profit Tier II shelters, but not from the welfare hotels.

Even taking into account the charges of "skimming" (e.g., accepting the most well-functioning clients) that are leveled against the Tier II shelters, it is not an accident that the re-housing rates for the Tier II shelters surpass those of the hotels. Not only are there more services, but the environments are more respectful of families as human beings. "It's a safe environment," stressed one director.

One mixed message advocates independence and self-sufficiency on the one side, while encouraging dependence and control on the other.

But even safe environments may give off subtle messages that can erode the regenerative capacities of homeless families. One mixed message advocates independence and self-sufficiency on the one side, while encouraging dependence and control on the other.

> "We see the effect on the parents more than on the child. This environment is intrusive; it lacks privacy. The mothers are constantly monitored. They must check in and out; they must verify their baby-sitting arrangements. Caseworkers are always prying into their lives. Teachers know all about their children. There is little privacy. Men are not allowed in. We can see the mothers become depressed, withdrawn, angry," said one Tier II provider.

A similar perception was echoed by another non-profit provider.

> "It's an unreal situation. No cooking facilities, no phone, no utility bills to budget for and pay, asking at the front desk for toilet paper. Particularly for those people who have never lived on their own, this experience does not teach independent living skills."

The experience of parenting in this context is very difficult.

The experience of parenting in this context is very difficult. Two researchers who have explored the relationship between mothers and their children staying in Atlanta shelters observed what they termed the "unraveling" of the mother's role as a consequence of shelter living. When once it was the mother's perogative as to when and what to eat, where and how to secure food, clothing, housing, and health care, now it was everyone's business but hers. Shelter living seemed to cause the unraveling of adult responsibility and the resumption of childlike behaviors as the adult role of "provider, family head, organizer, and standard setter" was taken over by others (Boxill & Beaty, 1986).

Service Delivery Challenges

The fragmented, at best, and horrifying, at worst, nature of programs for homeless families in New York City can perhaps be attributed to three things: (1) the spit-and-glue approach to program design, (2) a lack of leadership at all levels of government: city, state, and federal and (3) the nature of the social service delivery system in New York City.

The Spit-and-Glue Approach. Too often things happen simply because nobody stopped and thought clearly enough about their implications. For example, what are the trade-offs inherent in providing an environment that is so

There has been no effort to planfully meet the needs of either the children or their families.

safe and predictable that it infantilizes those who live there, and undermines their sense of autonomy? On a larger scale, what have been the ramifications of over-reliance on hotels as "temporary" shelters for families, when it was clear, as early as 1981, that the numbers of homeless families were growing and the length of time they were homeless was increasing?

In spite of the fact that homeless families are essentially a captive audience, opportunities for serving them are not being exploited. There has been no effort to planfully meet the needs of either the children or their families. There have been no large-scale systematic efforts to:

- Immunize children
- Enroll children in school
- Ensure adequate pre- and post-natal care and
- Provide intensive case management and other preventive services.

Fears of "institutionalizing" homelessness are merely rationalizations that distract attention from some of the hard questions that must be asked.

In effect, there is no one stepping back and considering the macro-level implications of the system as it is currently configured. Fears of "institutionalizing" homelessness are merely rationalizations that distract attention from some of the hard questions that must be asked. However critical the attention to the macro-level issues of housing needs has been, it is not enough. What is also essential is a stronger focus on proactive efforts that will prevent further damage to the children, enhance their development, and help parents develop new competencies not only in coping with homelessness but also in functioning successfully once housing is available.

Lack of Leadership. A lack of leadership at all levels of government has allowed for circular fingerpointing and abdication of responsibility for the effective support of homeless families. The City blames the State and the State blames the federal government. And nobody monitors anybody. Although mandated by law, there is no quality control requirement for federal Emergency Assistance programs. On the state level, although there is a system of regulations in place, the State seems not to be enforcing its own policies. And in New York City, many observers say that the City takes the attitude that it doesn't have to comply with State regulations. In particular, the message is that if temporary shelter is made "too good," then everyone will want it.

A lack of leadership at all levels of government has allowed for circular fingerpointing and abdication of responsibility for the effective support of homeless families.

And so policy has been driven by litigation. The seed for it all was Article XVII in the New York State constitution which declared that the "aid, care and support of the needy is a public obligation." On Christmas Eve, 1979, the Court ordered the City to provide shelter to men who needed it. This was followed several years later by equal protection for women. In 1986, they were joined by families. However, not until June 1987 was emergency shelter for families required to satisfy "minimum standards of sanitation, safety and decency." Other litigation has been filed challenging the placement of pregnant women, infants, and children or adults with infectious diseases in Tier I shelters; the placement of families in shelters with lead paint and asbestos hazards, and without adequate sanitary facilities; the prohibition of visitors at the Hotel Martinique; the City's failure to provide school transportation grants to homeless families; and other City practices, most of which are in violation of State regulations (see The Legal Aid Society, 1987).

In the public and non-profit sectors, the delivery of social services is both fragmented and uncoordinated.

The Nature of the Social Service Delivery System. It is nothing new to point out the obvious---that in both the public and non-profit sectors, the delivery of social services in New York City is both fragmented and uncoordinated. The needs of the child and of other family numbers are met piecemeal---health care programs, child welfare/social services, day care, nutrition programs---none of them exists as part of a larger family-based service delivery plan. In both sectors, there are multiple agencies, each with separate staffs, separate funding streams, and separate chains of accountability. One welfare hotel we visited had a rich array of services offered by an equally rich array of providers. But there was no sense of how families were actually being served. There were separate head counts of how many lunches were being served, how many medicals were given, how many children were enrolled in the on-site day care program, etc., etc, but no one knew which families had access to what constellation of services and how those services may or may not have supported the family's move toward self-sufficiency and which families had access to none.

Communication is a problem both within and across sectors. At one hotel, we were told that there is a monthly meeting among service providers. "The Board of Ed. doesn't come, [and] there isn't much interaction between the Crisis workers and the rest of the service providers." "It's hard to communicate to each other about what's going on and when." "You can't just call up a Crisis worker and find out why a child wasn't at day care," were other things we heard.

Particularly renowned in the public sector is its lack of flexibility to deal with things except by "the book." We were told one story about a working mother and her two children staying at a Tier I congregate shelter in Brooklyn. Because the mother was working, she was not eligible for Medicaid. She belonged to a HIP program in Manhattan. One of the two children became sick and needed immediate hospitalization. The shelter would only refer the child to Kings County Hospital. However, since Kings County is not a HIP center and the mother is not on Medicaid, she is now faced with a $500 medical bill.

Both public and non-profit systems share an unfortunate proclivity toward undermining family integrity and stability.

Fragmented and inflexible services are not the exclusive domain of the public sector. One Tier II provider we visited was served by two medical facilities---a clinic in a nearby hospital and a mobile van. The health van, however, could only make referrals to a hospital at a considerable distance from the shelter---not to the neighborhood hospital. In addition, unless informed by the patient, there was no mechanism for informing either provider of the use by the patient of the other's services.

Both public and non-profit systems share an unfortunate proclivity, albeit largely unintentional, toward undermining family integrity and stability. For the non-profit Tier II providers, the restrictions of many Tier II shelters to women and young children means that those fathers who want to maintain an ongoing relationship with their families are prevented. During one visit to an on-site day care program at a Tier II shelter we observed LaShandra, a talkative, good-natured 3-year-old, playing with a puzzle. Looking up, she saw a man looking through a window. She stopped her play and exclaimed with a wide grin, "that my Daddy, come to take me away!" The man, however, turned and walked away. LaShandra sat quietly, put her head down and sobbed quietly for 10 minutes. For the rest of the day, she sadly pouted with her thumb in her mouth. What is the impact of one instance multiplied by many on the parent-child relationship, on the child's sense of value and self-worth, on the view of men in a culture in which they are already largely marginal players?

The lack of system supports and coordination of services among City agencies also works against family integrity.

The lack of system supports and coordination of services among City agencies also works against family integrity. Particularly horrifying is the encouragement of voluntary foster care placement (fought against in the courts and presently under appeal). The not-so-subtle message is that a parent is not fit to be a parent if s/he lacks a home. Yet a family must be homeless for 18 consecutive months in order to receive active assistance from the City in getting rehoused. In some cases, there is no longer a family left to re-house.

The Split of Services to Parents and Children. We seem to be stubbornly ignoring what we know. We know, for example, the power of early intervention efforts on young children's growth and development. We also know that for program effects to be lasting, a comprehensive, family-based approach is critical. Yet, among the homeless population, young homeless children and their parents are among those least likely to be the targets of focused intervention programs. Among existing services, there is little linkage between programs for children and their parents, even when the connection seems obvious. Publicly-funded day care for homeless children, for instance, is provided, not because of the possibilities it offers for the child's enhanced development or support of the parent-child relationship, but because supervision is needed while the parent searches for housing. In one program we visited, there were day care and social service and mental health components all on site, but the day care teachers and caseworkers were not allowed to share information about each other's respective "clients;" yet, both parent and child were part of the same family unit. And, as was illustrated in the previous section, to optimally meet the developmental needs of the young child, it is important to understand aspects of the family situation.

There is no one person to whom families can turn.

The Lack of Continuity in Service Delivery. Even in the best of cases, the lack of continuity of services is a serious problem. Continuity is an issue on several levels, the most basic of which is geographical. As the shelter system is presently configured, the most vulnerable, socially isolated families are removed from their former neighborhoods (see Table 2, p.30) and whatever support systems still may have remained, especially school, church, IM center. They are overwhelmed with a barrage of services, all delivered by different strangers and subject to different administrative procedures. Then at the moment of re-housing---in another new neighborhood---all the supports are removed cold turkey. And if "new" means a deteriorating, *in rem* building, then the likelihood of finding comprehensive service networks nearby is small.

Interpersonal continuity within the service delivery system is also lacking. There is no one person to whom families can turn. A homeless family's first encounter is with a worker and a nurse at an EAU. Upon arrival at a hotel, a caseworker from Crisis Intervention Services (CIS) takes over a family's case, along with 59 other cases. Special Services for Children (SSC) which handles child welfare issues, is not involved except if abuse or neglect is suspected. Rather, the CIS caseworker, who is from the Adult Services Agency, is responsible even though the majority of clients are children. Upon the move to the hotel, the family's IM center also changes location (the IM center, which is within a different HRA agency, retains responsibility for the family's benefits). When a family is re-housed, its records are transferred to yet another IM center, and the relationship with the hotel caseworker is terminated. At this point, a caseworker from OFS (Office of Family Services, within yet another HRA agency) visits the family within five days after the family is re-housed. If the family doesn't want the contact, that's the end of any on-going follow-up. If there were any children in day care, eligibility is supposed to be transferred to a new ACD site. However, if ACD isn't informed that the family is being re-housed (and it usually isn't), then that agency contact must also be renewed---now within a new ACD Resource Area.

In Tier II shelters, caseloads are smaller (12-22 clients vs. 60) and caseworkers tend to be able to negotiate the system for their clients in a less complicated way. However, in both systems, pressures are aggravated by staff burnout and consequent turnover. This is a problem shared by all human service providers (Gallagher, Markowitz, & Zhon, 1987), but it is made worse by the strains of dealing with continually difficult cases and intransigent bureaucracies.

A third aspect of continuity is continuity over time. At what point is intervention most appropriate: when a family is at-risk of homelessness, at the onset of homelessness, or after re-housing? Certainly there should be intervention at all points in time. HRA, through its Housing Alert program, is trying to rally resources around families at-risk of losing their housing. Located in only two community districts, this is still a small-scale initiative.

Efforts to follow-up families upon their move to permanent housing are minimal at best. Although called transitional, existing shelters have few to no built-in transitions. The sudden break with services, combined with geographical dislocation, could actually act as a disincentive for independent living. Again, we must consider what message we are giving vulnerable families at critical moments in their lives.

By the year 2003, there may be more than 18 million people nationwide who will be homeless or close to it.

> "Programs remain uncoordinated, resources are not rallied. Most significantly, the present division of agencies virtually guarantees that no comprehensive approach will be undertaken to deliver the many services New York has to offer to the children within it." (Tobis, 1987, p. 223)

Issues for the Future

At the peak of the Depression, on any given night in New York City 9,400 people were without homes. Tonight, there will be close to 28,000, including 12,500 children. By the year 2003, there may be as many as 18 million people nationwide who will be homeless (Smith, 1988). Perhaps more insidious than the numbers which, like body counts during the Vietnam War, have begun to lose their shock value, is just how ordinary it is all becoming. "Where you live? Upstairs?" 3-year-old Iris asks a visitor in the lobby of the Martinique Hotel. Where else?

We have not been examining the issues long enough to generate a firm set of recommendations. But we raise here a set of issues that have the potential to improve the quality of life for homeless preschoolers and their families.

Citywide Leadership Around the Provision of Services to Children. As presently configured, there is no central office or person on the City level responsible for rallying services around homeless children and their families. Programs are sometimes both inadequate and duplicative. Data are scattered or nonexistant. In short, there is no one

There is no one whose job it is to worry about children.

whose job it is to worry about children. To the best of our knowledge, there has never been a meeting of key public officials with responsibility for serving homeless children. Indeed, only the Board of Education seems to have established a special focal-point for leadership on this issue, and yet their efforts in the field have been found inadequate.

Not all families need a full complement of services. Many just need intensive levels of support that ad hoc approaches cannot provide.

In the absence of a strong mandate from within the key City agencies, and ideally from within the Mayor's Office, progress on serving homeless children, and particularly preschool ones, will be slowed. Therefore, strategies should be explored for convening, perhaps under a Foundation auspice, a working group of City officials to explore better services for children in the hotels, particularly preschool children.

Enforcement of Existing Regulations. The New York State Department of Social Services has promulgated regulations which require that certain procedures be followed and certain services made available to homeless families and children (with decreasing levels of specificity and stringency for Tier II shelters, Tier I shelters and commercial hotels, respectively). New York City, however, is somewhat selective in its compliance, and New York State rather weak in its enforcement. Both need to change. New York City must stop its foot dragging and New York State must put some teeth into its enforcement procedures.

Development of an Individualized Family-Based Service Plan. There are wide ranges of need. Obviously, not all families need a full complement of services. Many just need housing. But some need intensive levels of support that *ad hoc* approaches cannot provide. Despite the compelling reality that for many homeless families, housing alone is not enough, there are neither the resources to provide, nor a clear mandate to develop, with the participation of the families, some kind of individualized family service plan. As noted in the text of this report, the existing social service regulations do not appear to go so far as to require an intensive multi-faceted plan, although they do require a written service plan designed to help the family achieve permanent housing. The absence of efforts to assist families beyond their housing needs is particularly dramatic in the hotels. Therefore, strategies ought to be explored to test out the impact of such efforts with the families, perhaps linked to some crisis intervention effort using an intensive home-based approach similar to that of the Homebuilders program (designed to prevent unnecessary foster-care placement) in the Bronx.

A profile of child development and family functioning linked to service usage is a critical missing piece in trying to understand which strategies are most effective for supporting homeless families and their young children.

Comprehensive Needs-Assessment. As a prerequisite to the development of an individualized family service plan, a comprehensive profile of child development and family functioning must be constructed. Presently, there is no procedure for assessing either a child's cognitive and socio-emotional development, or the family's overall level of coping. As a result, services are flung at families without attempting to optimally match services with a family's implicitly or explicitly expressed needs.

More broadly, our lack of knowledge about homeless families as a whole makes the design of appropriate models of inter-agency service delivery systems problematic. At present, data is spotty at best. Primarily, it is anecdotal. A profile of child development and family functioning linked to service usage (as well as length of time homeless) is a critical missing piece in trying to understand which strategies are most effective for supporting homeless families and their young children.

Negotiating the maze of service system bureaucracy can tax the most well-functioning of persons. As one social worker described it to us, "As soon as you think you understand it, it changes again."

Coordination of On-Site Services. We heard from program providers time and time again about the fragmented and uncoordinated nature of services, even within a single site. There is no clear mandate for devising a services profile for children and families, so as to determine which families are served in what ways, and which families are slipping through the cracks. This is a very difficult problem to deal with given the extent to which service providers, especially in the hotels, are overburdened. Nonetheless, it might be possible to experiment with creating a support system for the hotel providers on a demonstration basis, that would also provide a chance for them to strengthen the on-site coordination of services. Seeking ideas from the providers in a selected hotel might be a place to start.

Flexibility of Services. Just as there needs to be a clearer differentiation of child and family needs, there also needs to be a more differentiated structuring of existing services. With respect to day care, for example, publicly-funded slots are for full-day daily programs, thus ignoring the need by some families for drop-in care only. Similarly, eligibility for certain preventive services does not kick in until a family may be on the brink of losing a child to foster care.

Case Management. New strategies of case management need to be conceived for working with this difficult population. Negotiating the maze of service system bureaucracy can tax the most well-functioning of persons. As one social worker described it to us, "As soon as you think you understand it, it changes again."

Vulnerable families, who are trying to do the best they can for their children, need the proactive efforts of a social service advocate. Presently, the bouncing of families from one caseworker to another depending on where the family is in the system is particularly intrusive on the family's privacy, and insufficient in terms of making and maintaining appropriate service linkages. New approaches that combine needs assessment, and ongoing case management need to be piloted for small clusters of families.

Continuity. A clearer mechanism is needed for facilitating the transition back to permanent housing. Continuity of services is critical for stabilizing families. Continuity of case management until new service linkages are "up and running" may be one way to minimize the stresses associated with relocation and the all too frequent breaks with services (e.g., administrative welfare case closings, loss of day care, non-transfer of records) it entails. Continuity of experience is especially key for making children feel safe and secure enough to learn. The bouncing from school to school or day care to day care is unnecessarily disruptive and potentially damaging on top of the many other discontinuities in their lives.

Proactive Support for Parents. Innovative strategies for supporting parents need to be designed. In particular, there needs to be special attention given to the mental health needs of homeless parents. Anecdotally, we kept hearing about the incidence of maternal depression, and about children being kept in their rooms---their mothers too depressed to dress them and send them to day care. Standard outreach techniques are not sufficient for reaching them.

In particular, we would like to see efforts to explore the development of two kinds of services: (1) intensive, family-focused short-term interventions designed to help families develop and carry out family goals (this would help counter the dependency press discussed earlier) and (2) support groups in which homeless mothers have the opportunity to draw strength and ideas for coping from one another. In developing the former, a modified Homebuilders approach seems to have some merit; in developing the latter, beginning models exist in some programs already, such as the Henry Street Settlement House's Urban Family Center.

In short, the crisis of homelessness can be made a positive crisis for families, if they are linked with appropriate services. Moreover, this can be made an opportunity to improve service delivery within the larger system. None of these efforts will, however, erase the basic need for housing to stabilize the lives of homeless children and families. At the same time, given the reality that housing alone will not be sufficient for many of them, moving forward on efforts to strengthen the services targeted to them can only reduce the stress, and indeed trauma, in the lives of so many of New York City's families, and improve the futures of their children.

REFERENCES

Bach, V. & Steinhagen, R. (1987). *Alternatives to the welfare hotel: Using emergency assistance to provide decent transitional shelter for homeless families*. New York: Community Service Society of New York.

Barbanel, J. (1987, December 12). New York, in policy shift, withholds rent from welfare hotel. *New York Times,* pp. B1, B6

Barbanel, J. (1988, January 26). Number of homeless far below shelter forecasts. *New York Times*, pp. B1-B2.

Barron, J. (1987, September 3). Schools are failing to serve children, Messinger asserts. *New York Times*, p. B5.

Bassuk, E.L. & Rubin, L. (1987). Homeless children: A neglected population. *American Journal of Orthopsychiatry*, *57*(2), 279-286.

Bassuk, E.L. & Gallagher, E.M. (n.d.). *The impact of homelessness on children*. Unpublished.

Bassuk, E.L., Rubin, L. & Lauriat, A.S. (1986). Characteristics of sheltered homeless families. *American Journal of Public Health, 76* (9), 1097-1101.

Beirut, L. (1987, March 1). Midtown south overburdened with the homeless. *Our Town*, pp. 1, 15.

Blaze at welfare hotel in Brooklyn injures 21 (1987, August 12). *New York Times,* p. B7.

Boxill, N. & Beaty, A. (1986). An exploration of mother/child interactions among homeless women and their children using public night shelter in Atlanta. Unpublished.

Bredekamp, S. (1986). *Developmentally appropriate practice.* Washington, DC: National Association for the Education of Young Children.

Bronfenbrenner, U. (1974). *A report on longitudinal evaluations of early childhood programs. Vol. 2. Is early intervention effective?* (DHEW Publication No. OHD 74-24). Washington, DC: Office of Child Development.

Carper, A. (1987, November 30). School reforms sought by Wagner. *New York Newsday.*

Chavkin, W., Kristal, A., Seabron, C., & Guigli, P.E. (1987). Reproductive experience of women living in hotels for the homeless in New York City. *NY State Journal of Medicine*, *87*, 10-13.

Chavez, L. (1988, January 14). New families are barred from hotel. *New York Times,* p. B1.

Children's Defense Fund (1982). *America's children and their families: Key facts.* Washington, DC: Author.

Children's Defense Fund (1985). *Black and white children in America: Key facts.* Washington, DC: Author.

Children's Defense Fund (1987). *Children's defense budget, FY 1988*. Washington, DC: Author.

Children's Defense Fund (1988, January). United States' progress in saving infant's lives has stopped according to recent data. *CDF Reports* 9(*8*), p. 1.

Cicchetti, D. & Aber, J.L. (1986). Early precursors of later depression: An organizational perspective. In L.P. Lipsitt (Ed.), *Advances in infancy research* (Vol. 3, pp. 87-137). Norwood, NJ: Ablex.

City of New York Department of Health (n.d.). *The homeless health initiative.* Article 47 of the New York City Health Code. Unpublished manuscript.

City of New York Human Resources Administration (1986, March). *Averting the need for emergency housing: The feasibility of an early warning system for public assistance families.*

City of New York Human Resources Administration (1986a, October). *A one-day "snapshot" of homeless families at the Forbell Street Shelter and the Martinique Hotel.* New York: Author.

City of New York Human Resources Administration (1986b, October). *Characteristics and housing histories of families seeking shelter from HRA*. New York: Author.

City of New York Human Resources Administration (1987, November). *New York City temporary housing program for families with children.* Monthly report.

City of New York Human Resources Administration (1988, January). *Five-year plan for housing and assisting homeless families.* New York: Author.

City School District of the City of New York (1987, March 31). *Students in temporary housing* (Regulation of the Chancellor, No. A-780).

Coalition for the Homeless (1984, December). *Perchance to sleep: Homeless children without shelter in New York City.* New York: Author.

Consortium for Longitudinal Studies (1983). *As the twig is bent...lasting effects of preschool programs*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Council of the City of New York Select Committee on the Homeless (1987, January). *Report on the homeless crisis.* New York.

Daley, S. & Meislin, R.J. (1988, February 8). New York City, the landlord: A decade of decay. *New York Times*, pp. A1, B2.

deCourcy Hinds, M. (1987, December 28). Welfare allowance going up but homeless worries persist. *New York Times*, pp. A1, B6).

Dehavenon, A.L. (1987). *Toward a policy for the amelioration and prevention of family homelessness and dissolution: New York City's after-hours Emergency Assistance Units in 1986-87*. NY: The East Harlem Interfaith Welfare Committee.

Dumpson, J.R. & Dinkins, D.N. (1987). *A shelter is not a home: Report of the Manhattan Borough President's Task Force on Housing for Homeless Families.* New York.

Escolona, S. (1982). Babies at double hazard: Early development of infants at biologic risk. *Pediatrics*, *70* (5), 670-676.

Fadiman, A. (1987, December). A week in the life of a homeless family. *Life*, pp. 29-38.

Felstein, C. & Stegman, M.A. (1987, May). *Toward the 21st Century: Housing in New York City*. New York: The Commission on the Year 2000.

French, H.W. (1987, October 2). 29 injured by arson at a welfare hotel in Harlem. *New York Times*.

Gallagher, D., Markowitz, D., & Zhon, Y. (1987). *Short staffed! The personnel crisis at New York City's voluntary human service agencies*. New York: Interface.

Grant, J. (1988). *The state of the world's children*. New York: Oxford University Press.

Gross, J. (1988, January 27). Healing on wheels: Treating welfare children. *New York Times*, p.A1, B24.

Gross, J. (1988, February 13). Cocaine and AIDS in New York add to infant deaths. *New York Times*, pp. A1, A30.

Hartmann, C. (1986). The housing part of homelessness. In E. Bassuk (Ed.), *The mental health needs of homeless persons.* San Francisco: Jossey-Bass.

Horton, G. (1987, September). *No one is responsible for these children.* Report prepared for the Office of Council Member Ruth Messinger.

Jordan, D. (February, 1988). Homes and homelessness. *Better Homes and Gardens*. Editorial.

Kozol, J. (1988). *Rachel and her children: Homeless families in America.* New York: Crown Publishers, Inc.

Lyons-Ruth, K., Botein, S., & Grunebaum, H.U. (1984). Reaching the hard-to-reach: Serving isolated and depressed mothers with infants in the community. In B. Colher, & J. Musick (Eds.), *Interventions with* *psychiatrically disabled parents and their young children* (pp. 95-122). New Directions for Mental Health Services, 24. San Francisco: Jossey-Bass.

Magnet, M. (1987, November 23). The homeless. *Fortune*, pp. 170-190.

McChesney, K.Y. (in press). Paths to family homelessness. In M.J. Robertson, & M. Greenblatt (Eds.), *Homelessness: The national perspective*. New York: Plenum.

Meisels, S.J. & Anastasiow, N.J. (1982). The risks of prediction: Relationships between etiology, handicapping conditions, and developmental outcomes. In S. Moore & C. Cooper (Eds.), *The young child: Reviews of research* (Vol. 3, pp. 259-280). Washington, DC: National Association for the Education of Young Children.

Miller, C.A. (1987). *Maternal health and infant survival*. Washington, DC: National Center for Clinical Infant Programs.

National Coalition for the Homeless (1987, May). *Homelessness in the United States: Background and federal response. A briefing paper for Presidential candidates.* New York: Author.

New York State Department of Social Services (1986, June 23). *Shelter for families Part 900*. Added to Chapter II of Title 18NYCRR.

New York State Department of Social Services (1986, June 23). *Standards of assistance Part 352.3*. In Chapter II of Title 18NYCRR.

Perlez, J. (1987, November 12). Thousands of pupils living in hotels skip school in New York. *New York Times,* pp. A1, B5.

Regan, T. (1987, September 17-23). Homeless children find school return a hard grade to make. *The Westsider*, pp. 1, 18.

Roberts, S. (1987, April 2). New York City on $13 a day: A welfare tale. *The New York Times,* p. B1.

Rosenberg, T.J. (1987). *Poverty in New York City: 1980-1985.* New York: Community Service Society of New York.

Simpson, J.H., Kilduff, M., & Blewett, C.D. (1984). *Struggling to survive in a welfare hotel*. NY: Community Service Society of NY.

Sirica, J. (1988, January 27). Homeless aid cuts blasted. *New York Newsday,* p. 15.

Smith, S. J. (1988, 5 February). New thinking about the homeless: Prevention, not cure. *Governing, 1*, 24-29.

Suit challenges housing plan. (1988, January 13). *Daily News.*

The Legal Aid Society (1987, July). *Litigation by the Legal Aid Society on behalf of the homeless in New York City: Selected cases*. New York: Author.

Tobis, D. (1985). Services to children. In C. Brecher & R. Horton (Eds.), *Setting municipal priorities: 1986* (pp. 207-234). New York: New York University Press.

Thompson, M.W. (1987, August 19). Room with a boo: They are put in banned hotel. *Daily News*, pp. 3, 27.

U. S. Conference of Mayors (1987, May). *A status report on homeless families in America's cities. A 29-city survey.* Washington, DC: Author.

U.S. Conference of Mayors (1987, December). *The continuing growth of hunger, homelessness and poverty in America's cities: 1987. A 26-city survey.* Washington, DC: Author.

U.S. House of Representatives Select Committee on Children, Youth, and Families (n.d.). *The crisis in homelessness: Effects on children and families.* Fact sheet.

U.S. House of Representatives Select Committee on Hunger (1987). *Hunger among the homeless: A survey of 140 shelters, food stamp participation and homelessness.* Washington, DC: U.S. Government Printing Office.

Vanderbourg, K. & Christofides, A. (1986, June). *Children in need: The child care needs of homeless families living in temporary shelter in New York City.* Report prepared for Ruth W. Messinger, New York City Council member, 4th District.

Wasserman, J. (1987, October). Homeless kids chaos: Ed board advocate quits over truancy. *Daily News*.

Winick, M. (1985). Nutritional and vitamin deficiency states. In P. Brickner, L. Scharer, B. Conanan, A. Elvy, & M. Savarese (Eds.), *Health care of homeless people* (pp. 103-108). New York: Springer Publishing Company.

Wright, J. D. (1987). The National Health Care for the Homeless Program. In R.D. Bingham, R.E. Green, & S.B. White (Eds.), *The homeless in contemporary society* (pp. 150-16). Newbury Park, CA: SAGE Publications.

Wright, J., Weber-Burdin, E., Knight, J. & Lam, J. (1987). *The National Health Care for the Homeless Program: The first year.* Amherst, MA: University of Massachusetts.

APPENDICES

APPENDIX A

Programs Visited

PROGRAMS VISITED

American Red Cross
- Emergency Family Center
- Family Respite Center

Association to Benefit Children
- All Children's House
- East Harlem Family Center
- Luis Sanjuro Day Care Center
  (Hotel Martinique)

Boys Harbor
- Boys Harbor Program
- Harriet Tubman Day Care Center

Children's Aid Society
- Prince George Hotel

Colony South Brooklyn Houses
- Amboy Street Day Care Center

DeWitt Head Start

Henry Street Settlement
- Urban Family Center

Jewish Board of Family and Children's Services
- Regent Hotel

Polly Dodge

Women In Need (WIN)
- Camp WIN
- Kids Care

APPENDIX B

Director's Interview

DIRECTOR'S INTERVIEW

PROGRAMS FOR HOMELESS FAMILIES IN NEW YORK CITY

Program ______________________________ Date __________

Interviewee(s) __________________ Title __________________________

__________________ Title __________________________

__________________ Title __________________________

Staff _________

Organizational Background

1. When was the umbrella organization founded? When did it begin operations in NYC? What was its original function? How has that evolved over time?

2. How many sites exist? Nationally, locally?

4. Are program sites owned by the umbrella organization? Leased?

Program

1. How did the program for homeless families begin? When did it begin? What were the motivating factors?

2. Were there barriers to initial start-up? How were they handled?

3. How are families/children recruited?

4. Does the program gear itself to particular kinds of persons/families? Are there any restrictions? Can a family be evicted?

Program Components

1. What kind of services does the program provide? To whom are each targeted? How many families/children are served? What kind of staff support is there?

COMPONENT FUNCTIONS FUNDING

STAFFING

2. How is attendance?

3. How secure is funding? Is there an ongoing battle for continued funding? What kind of help does the parent organization provide?

Families

1. Where are the families from (i.e., where did they live before becoming homeless)? Did many of them live doubled up with relatives or friends?

2. What are the some of the precipitating factors that led the program's families into homelessness?

3. Is there a "typical" family profile (i.e., average number of children & their ages, are there others in foster care, age, ethnicity, & education of mother, AFDC recipients)? In general, what are the families/children like?

4. Do you encourage involvement of parents in the program? How are parents involved? Do you have a core group of involved parents? What is your attendance like at parent meetings/activities? Are there parents who don't participate at all? Why not?

Challenges

1. What barriers are there to effective program implementation?

2. What are the program's key accomplishments?

3. What are the key issues facing the children and families being served?

4. What program services are most effective in supporting families? Why?

5. Are there families/children not being served by any program? Why?

6. What is the future for these families? If things will turn out differently for some families than others, why is this so?

7. What policy recommendations make the most sense for the City to consider? The State?

Materials Distributed

Materials Received

APPENDIX C

Classroom Visits

American Red Cross Emergency Family Center

CLASSROOM VISITS

American Red Cross Emergency Family Center

August 27, 1987

September 3, 1987
September 16, 1987
September 22, 1987
September 30, 1987

October 7, 1987
October 14, 1987
October 28, 1987

November 3, 1987
November 18, 1987
November 25, 1987

December 2, 1987
December 16, 1987
December 23, 1987

January 6, 1988
January 12, 1988
January 19, 1988
January 26, 1988

February 2, 1988
February 16, 1988

APPENDIX D

Roundtable Participants

Highlights of the Roundtable Discussion

BANK STREET COLLEGE OF EDUCATION
Division of Research, Demonstration & Policy
RESEARCH/POLICY ROUNDTABLE ON HOMELESS CHILDREN AND FAMILIES
November 19, 1987
LIST OF PARTICIPANTS

J. Lawrence Aber, Ph.D.
Department of Psychology
Barnard College

Garth Alperstein, M.D.
New York City Dept. of Health
Bureau for Families With
Special Needs

Ann Barnet, M.D.
Children's Hospital
National Medical Center

Ellen Bassuk, M.D. *
Harvard Medical School

Nancy Boxill, Ph.D.
Atlanta University

Patricia Cohen, Ph.D.
Columbia University School of
Public Health
New York State Psychiatric
Institute

Jean Garrison, Ph.D.
Community Service Systems Branch
National Institute of Mental
Health

Carolyn Goodman, M.D.
Bronx Psychiatric Center
PACE Family Center

Kay Young McChesney, Ph.D.
Department of Sociology
Indiana University of
Pennsylvania

James Knickman, Ph.D.
Graduate School of Public Admin.
New York University

Beth Lief
The Edna McConnell Clark Fdtn.

Ira Lourie, M.D.
Child & Adolescent Service
Systems Program

Lisa Mihaly *
Children's Defense Fund

Ruth Parker, M.D.
Robert Wood Johnson Clinical
Scholars Programs
University of Pennsylvania
School of Medicine

Deborah Rog, Ph.D.
Program for Homeless Mentally Ill
National Institute of Mental Health

Marybeth Shinn, Ph.D.
Psychology Department
New York University

Amy Somers, Ph.D.
Homeless Health Institute
New York City Dept. of Health

Noemi Velez, Ph.D.
Columbia University School of
Public Health

Beth Weitzman, Ph.D.
Graduate School of Public Admin.
New York University

Barbara Whitman, Ph.D.
Cardinal Glennon Hospital
St. Louis

David Wood, M.D.
The Rand Corporation

Jane Knitzer, Ed.D.
Janice Molnar, Ph.D.
Annelie Hartmann
Tovah Klein
Blanca Ortiz
Liz Westfall
Bank Street College of Education

* Unable to attend at the last minute.

BANK STREET COLLEGE OF EDUCATION
DIVISION OF RESEARCH, DEMONSTRATION & POLICY
HIGHLIGHTS OF THE ROUNDTABLE ON HOMELESS CHILDREN & FAMILIES
NOVEMBER 19, 1987

The following text summarizes some of the highlights of the Roundtable discussion. In the following summary, it should be noted that participants are usually cited by name only in the context of their own research or interventions which have not been summarized previously.

Session I: WHAT DO WE ALREADY KNOW ABOUT THE IMPACT OF HOMELESSNESS ON CHILDREN AND FAMILIES?

In the morning session, the discussion was focused on current knowledge from research, service, and policy perspectives, about the impact of homelessness on children and families, above and beyond the effects of extreme poverty. Some of the issues which emerged from this discussion are summarized below.

* There was a consensus among the participants that there are "overarching" macro-economic factors, such as the housing shortage, and cuts in federal programs for low-income families, which are major forces in the dramatic increase of homeless families in recent years. There was not agreement, however, as to what role family disorganization contributed to the process of becoming homeless.

* Several participants made note of the increasing tendency to "institutionalize" a whole separate system to deal with the homeless population. It was argued that new services do not need to be created especially for the homeless, but that better coordination is needed among existing programs which offer services to poor families.

* Sampling was raised as a critical issue in evaluating research on the homeless. It was pointed out that currently there are no "bare minimum" standards for shelters, with respect to the quality of life and the provision of minimal services. Therefore, there are wide variations among shelters in terms of the populations served, services provided, and the quality of life within the shelters. Thus, researchers must randomly sample from a variety of shelters, and obtain very large samples in order to get representative and useful data for policy and program purposes.

* To make a comparison which could test hypotheses about homelessness, it was suggested that more inter-city comparisons be made to examine the impact of "macro-level" factors such as housing stock, policies, and economic factors. This could be an alternative to comparing housed poor to homeless groups, which always compare a slightly better-off group to the extreme.

* In terms of using comparison groups, it was cautioned that we should pay attention to the meaning of poverty across different contexts. For instance, the same poverty level might mean different things in a public housing project where there may be strong social support networks and social resources, than in the more general population of housed poor.

* It was also pointed out that we do not need to argue about "main effects", because homelessness is a multi-determined process. It was therefore suggested that we develop probabilistic risk models, in order to predict who is most at risk of becoming homeless, and to plan appropriate prevention strategies and interventions.

* It was also pointed out that there may be a "double filter" operating to first select the most vulnerable families into homelessness, and then later to select out the most competent and high-functioning families to emerge soonest from their homeless situation. Therefore, research needs to be longtitudinal to capture this process.

* Another caution was expressed that due to gross and insensitive developmental measures, we may wind up "proving" what isn't true: that housed poor and homeless children do not differ. This is reminiscent of research in the late 1970's, in which the policy and research question was whether abused and neglected children differed from children from poor, chaotic families. The insensitivity of the measures made it appear that these two groups did not differ.

* From a qualitative and phenomenological perspective, it was argued that by being descriptive and emphasizing the context of behavior, instead of utilizing "deficit" models of development, researchers could avoid further stigmatizing homeless people.

* It was the opinion of some participants that much of the research coming out of New York City was of limited applicability elsewhere around the country, although these between-city differences must be accounted for. To this end, researchers need to be very descriptive about their studies in general, and particularly about their samples, but also need to go beyond description to get at process issues.

* Homelessness was described as a "secular" trend in which decreased housing stock for low-income people, an increase in single-parent families, and poverty are converging to exert more pressure on families. Although there seems to have always been "multiple problem" and "dysfunctional" families, now homelessness is emerging as an additional factor to push more families beyond the point at which they can function well. With respect to this point, it was cautioned that we must not impose our own conceptions of "dysfunction" on families, and that we be sensitive to cultural issues.

* From a service perspective, it was noted that the problems which are commonly observed with welfare children are exacerbated with homeless children. This is because homelessness is at the "extreme" of a poverty continuum.

* Nancy Boxill reported observing what appeared to be serious language impairments among children living in night shelters in Atlanta. However, she noted that after the children move to a smaller and less chaotic transitional shelter, their language

abilities appear to be developmentally appropriate within days. Thus, what might be considered a "language deficit" could instead be understood as an adaptive response to a context of continual noise, chaos, and lack of privacy and space. This might also be an issue of competence vs. "displayed" ability. However, both David Wood and Barbara Whitman noted language delays among young children even in the "better" shelters.

* Other participants offered their observations of children in shelters. It was noted that children in the night shelters tend to mirror the depression of their mothers, in terms of low affect, appetite disturbances, etc. Children in shelters are reported to display many regressive behaviors which suggest that their basic security is threatened, such as regression in toilet training and language. Mothers report that their children become hyperactive, aggressive, or withdrawn after living in hotels.

* Garth Alperstein described some findings from a retrospective study he has been conducting of more than 300 children at an outpatient clinic in New York City, using comparison groups of housed vs. homeless children over a 2 1/2 year period. In terms of traditional indices of health care, such as immunization rates, hospitalization rates, and incidence of child abuse and neglect, his study found homeless children to be substantially worse off than housed poor children. Other findings were that the height and weight distributions of homeless children were more likely to be below normal than those of housed children; that there was twice the rate of iron deficiency, and a higher incidence of elevated lead levels for homeless children. Emotional problems among the homeless in this sample were also very high relative to the housed poor.

Dr. Alperstein also described a recent survey of the medical records of children living at the Martinique Hotel. Seventy-five percent of these children were found to be under-immunized or non-immunized. Among children in a housed poor sample, the comparable rate of non-immunization and under-immunization was 8%.

* Barbara Whitman introduced the notion of "competing competencies" to describe a phenomenon she has observed with homeless children, in which there are often language delays accompanied by a heightened sensitivity to nonverbal cues, or reading of interpersonal dynamics ("street smartness"). It was pointed out that this sort of development was survival-oriented and very adaptive to life in a shelter. These children, in effect, do not need language abilities as much as they need to "read" the nonverbal, interpersonal environment.

An important distinction was made about adaptation in this context: adaptation to the immediate environment of the shelter may prove to be maladaptive in the long-term developmental sense. Thus, adaptation to the shelter situation may hinder later adaptation to the school situation for homeless children.

* It was pointed out that the development of curiosity, language, and other cognitive processes are not isolated developmental events, but are integrally related to the security of the child and particularly, to the secure attachment of the child to the parent. Often, the parent-child relationship is disrupted in the shelters because parents are preoccupied with survival issues and are experiencing enormous stress.

Session II: WHAT STRATEGIES ARE MOST EFFECTIVE FOR SUPPORTING AT-RISK FAMILIES?

During this session, the discussion was focused on intervention strategies to support homeless families, as well as general issues in prevention.

* While there was a consensus that the housing shortage and other macro-economic factors constitute the "overarching" policy context for homeless families and children, there was some debate as to what the prioritization of housing and economic issues versus mental health and child development issues should be. It was pointed out that these are factors which have complex interrelationships, and that they are indeed, "mutual" needs (i.e., housing and child development, economics and family functioning are inextricably linked).

* One observation which was corroborated by several participants was the extreme isolation and alienation of homeless mothers toward each other. There is a tremendous fear of the shelter and everything it means, and mothers are afraid to help one another.

* The issues of timing and specificity were raised with respect to supportive interventions. Given that there is a process over time, during which families are in need of preventive efforts to remain housed, or to receive supportive services while in shelters, or are in need of follow-up services after leaving shelters, there needs to be a better understanding of these transitions in order to effectively support families. There also needs to be a greater sensitivity to the special needs of families in shelters. For instance, it was noted that in New York City, families are sheltered under the same system which evolved to serve homeless single men.

* It was suggested that basic needs assessment methodology could be used to take account of risk factors and "peculiar" needs of families in order to develop "individualized" family plans for services and support. Such an assessment should examine both external factors, such as family resources and formal/informal support networks, as well as internal factors, such as family adaptation, cohesion, mother-child interaction, etc.

* Nancy Boxill described an intervention in Atlanta, in which the goal was to enable mothers to reassert order and control over their lives, by providing them with opportunities to strengthen their maternal roles and make decisions for themselves and their families. Families are placed in a small, transitional shelter for six months, where mothers can reestablish their maternal roles in a non-institutional, home-like environment. She noted that in the night shelters the mothers' roles were beginning to "unravel", e.g., selecting food, cooking, and feeding their kids meals was no longer possible, and many role functions had become "institutionalized" by the shelters.

* Kay Young McChesney described four pathways to homelessness for families, based on her research: 1) mothers leaving relationships, who lose their homes and source of economic support; 2) homeless teens who "age out" of the foster care/juvenile system and become homeless mothers; 3) unemployed couples, where the primary breadwinner has lost their job. These include families who have either been recently evicted from local dwellings, or migrants (the

"Okies" of the 80's), who have migrated primarily for economic reasons; and 4) AFDC mothers. Participants added two more groups to this taxonomy: 5) young mothers who have previously lived with their families of origin; and 6) Latin American refugees. It was noted by several participants that there needs to be a better description of developmental pathways for homeless families and children.

* The question arose as to whether homeless mothers who place their children in foster care could be placed with their children in a "surrogate" family situation, perhaps on the "safe homes" model of battered women programs.

* The situation of families with adolescent children was highlighted. Many shelters, such as hotels, will not accept families with adolescents, and only some shelters will accept children over the age of 6 to 10 years.

* The case was made for early interventions for homeless children, who go from birth to 6 years of age before they go to school, but very few of whom are in any early education programs.

* Ruth Parker noted that in Philadelphia, there is a prohibition against childcare in the public shelters. The rationale is that mothers will "abuse" such services, abandon their children, or be otherwise irresponsible. Ann Barnet reported that in Washington, D.C., there are 25 daycare slots for the entire homeless shelter population.

* Nancy Boxill noted a system of providing childcare for homeless in Atlanta, which tried to avoid problems associated with setting up a childcare program by calling the program a "children's shelter." A voluntary network was used to raise money to purchase existing childcare services, and especially to assist with transportation, infant care, and second shift care. It was noted that while childcare seemed to enable mothers to move quickly into employment, they continued to have problems with childcare once they left the shelter. This is exacerbated by the fact that most of these mothers are going into low-paying entry-level jobs.

* It was the opinion of some of the participants that one of the provisions of the Stewart B. McKinney bill institutionalizes homelessness on another level by creating a separate system to ensure that homeless children go to school, e.g., the creation of a position of a State Educational Coordinator for homeless children. Again, it was argued that there is a lack of coordination of existing services, and that what may be needed is traditional social work advocacy to mobilize fragmented social services. There was a consensus that we need to integrate homeless children and families back into mainstream systems instead of creating a seperate constellation of services to deal specifically with the homeless.

* It was suggested that cities are afraid to encourage people who are presently "doubling up" to enter the shelter system by providing services such as childcare, thereby making this option even marginally more palatable for families. As one participant put it, the fear of social service bureaucracies is the "revolution" of rising expectations. Particularly for AFDC families with limited options, families might choose shelters over "doubling up" if shelters were to offer better services than they do currently.

It was also argued that we should not create "double standards" for the poor and for ourselves; that is, all people need to exercize options and control over their lives, and this is no less true for homeless families.

* Again, it was observed that the isolation and fear of the mothers is enormous, and that interventions to facilitate mutual support groups and babysitting exchanges are needed. However, it was also pointed out that cooperative living/mutual support programs need an educational and training component in order to have a chance of succeeding. It is unrealistic to simply bring mothers together to "help" each other, without providing concommittant support, education and guidance. We must foster opportunities for support networks to develop.

* In Atlanta, families will enter the shelter system because they will then be given priority for public housing. Frequently they can obtain public housing within 6-9 weeks of entering a shelter. In contrast, in New York City, families wait in shelters for public housing for up to 18 months.

* Given that we have limited money, is there a "bare minimum" for everyone, as opposed to creating innovative programs which usually help the "cream" of the population? It was suggested that comprehensive case management which would mainstream families into permanent housing over a period of a few years would be more efficient and not less costly than housing families in hotels for long periods of time with fragmented services.

* At the policy level, homelessness and housing must be linked. At the program level, we need new permanent housing, childcare programs, and efforts to foster supportive networks. What is needed is the political will and comittment to address these human needs. Housing is "permanency planning" for the homeless, and we are only playing a shell game if we don't increase the total number of housing units.

At the policy level, it was argued that housing, child development, and family survival must be linked. This would include the long-term, social-emotional and developmental consequences of homelessness, e.g., special education, juvenile delinquency, etc.

Session III: WHAT ARE THE MOST EFFECTIVE WAYS OF MEASURING CHILD DEVELOPMENT AND FAMILY FUNCTIONING?

The third session was devoted to methodology and measurement issues, particularly in terms of assessing child development, family functioning, and changes over time. Participants discussed both general issues and problems of research, as well as the relative merits of specific measures.

* The point was made that homeless children do not differ from other children in terms of developmental processes. Therefore, we need to look to theories of development to understand the impact which homelessness has on children, through the disruption of generic developmental processes, such as security and attachment.

* It was observed that finances and setting constraints often limit the choice of measures. There has also been a tendency to use measures, such as the Denver Developmental Screening Test, or the

Gessell, simply because they have been used before in other studies, and have established norms, validity, etc. However, these measures are not without problems.

* There are difficulties in administering test batteries in the shelters with this population. These include the general chaos, lack of privacy, and noise in the shelter, as well as chronic hunger and attentional difficulties children may be experiencing. One way of dealing with the attentional problems is to spread the testing out over time. Another solution offered by a participant was to do the assessment in a van parked outside of the shelter.

* Several participants raised concerns that testing be done in the context of service development, e.g., individual educational plans. It was also cautioned that researchers must be careful how results are reported, because results can be misused and taken out of context. Additionally, measures must be "easy" on families, i.e., not too intrusive or difficult and time-consuming to administer.

* It was argued that there must be a logic to using a certain protocol. Developmental measures must be age-specific, and multiple measures should be used to assess functioning. It was observed that we do not need to "duplicate" the research of twenty years ago, and that researchers need to balance the development of better measures with the advantages of using conventional measures (i.e., policy ready results). Although conventional measures are normed on huge populations, they tend to be insensitive to changes over time, or to motivational/emotional issues in test-taking.

* To get a "baseline" for IQ measures, Barbara Whitman gets a measure for both child and parent. She assesses functioning in cognition, language, and emotional adjustment. Ruth Parker tries to get a measure of mothers' IQ and depression along with mothers' reports of child behavior.

For assessing emotional status, the House-Tree-Person has been used. The Beck Depression Inventory (BDI) has to be used "with caution", however, because it contains items which are inappropriate for a shelter population. The Center for Epidemiological Studies Depression Scale was recommended by Larry Aber as more appropriate for this population, with a more sensitive gradient. Noemi Velez suggested the Diagnostic Interview Schedule (DIS), which is a structured interview format to assess depression. It was argued that the goal of assessment should be to get a sense of functional impairment of the person.

* Pat Cohen noted that in her research, the use of power assertive punishment (e.g., screaming, yelling, coercive control, etc.) was an "overwhelming" predictor of depression in mothers, and was linked to child maladaptation. Depressed mothers are as likely to use these methods of control as abusive/neglectful parents. She has a scale which she has been using to assess this dimension of parenting.

* Larry Aber argued that other methods of assessment might be more appropriate, sensitive to change over time, and easier on families. Q-Sort descriptions which avoid the problems of rating scales, can be used as a repeated measure and are also useful for non-obtrusive, structured observations of language.

Another alternative to assess family interactions might be to videotape parent-child interaction, taking a random sample of behavior. Larry's scoring system assesses the "Big 3" dimensions in current parenting research: sensitivity, control, and responsiveness. This scoring system can be used over a wide age group and is not enormously "micro-analytic." This method requires some coder training, but can reliably distinguish between abusive/neglectful and non-abusive parents of comparable SES groups.

* It was pointed out that in using parent-report measures of children, there are problems of bias. Even when using staff ratings to supplement parent reports, there is still the problem that raters are not blind, and therefore are biased to some extent. This is why Pat Cohen recommends direct interviews with children. Of course, this means only children who can self-report can be interviewed. When trying to assess parent-child relationships, researchers would do well to interview both parent and child.

* In terms of overall family functioning, some of the variables of interest to researchers were family conflict, conflict resolution, marital and parental discord. Pat Cohen mentioned that she has about 40 measures to assess family interaction.

* To assess peer interaction, Larry Aber suggested a Q-Sort technique which can be used in a daycare setting, as well as videotapes which assess children's ability to detect intention cues. According to research, children first learn to identify hostile intentions, then prosocial intentions, and lastly ambiguous intentions. The methodology is for a videotaped sequence to be shown to the child, who is asked to make judgements about the behavior depicted. Staff need about 6-14 hours of training to get good reliability for coding.

* Kay Young McChesney has a measure of social networks which specifically assesses support in the domain of housing. Beth Shinn and Jim Knickman are adapting this scale for use in their study to assess the extent to which families have already exhausted their housing support. Larry Aber noted that in his study in East Harlem, housing problems and family support were extremely negatively correlated.

* Jane Knitzer suggested researchers look at the Child Well-Being Scale which was developed by the Child Welfare League. It is designed for use with workers in family preservation research.

* David Wood mentioned that the Welfare Research Project at the Rand Corporation has an interest in developing measures.

Session IV: FUTURE DIRECTIONS.

The Roundtable discussion ended with suggestions for future agendas and advocacy efforts, as summarized below.

* There was general agreement that there should be a continuing information and resource exchange network among participants. For instance, literature reviews, bibliographies, and measures could be exchanged. Another possibility might be a cross-site study with common protocols.

* Suggestions for future meetings included instrument-focused presentations and discussions, particularly in terms of "distilling" experience with measures, as to what does and does not work, relative

merits, etc. These measures could be distributed ahead of time, and the purpose of the measures discussed and clarified.

It was also emphasized that service providers and program administrators be included in future endeavors, as a valuable source of information and "reality testing" about homeless families and children.

Several participants noted the need to look at "burnout" in the frontline staff of programs, shelters, and services. Lack of training and support, and low pay are endemic for these workers.

* Participants were in general agreement that the political impact of research must be maximized. Toward this end, it was suggested that research summaries be sent to legislative staff and advocacy groups, such as The Children's Defense Fund, because these groups are often unfamiliar with issues of child development. It was also suggested that there be a survey of Roundtable participants to get lists of groups to target for such advocacy efforts, e.g., sending research summaries, etc.

* It was cautioned that advocacy roles may have an adverse impact on access for researchers. This is because when researchers advocate for services, they are implicitly criticizing agencies which provide services, thereby endangering those services.

It was suggested that the potential outcomes of studies need to be anticipated, as well as how one can advocate with these different outcomes. Research and advocacy roles always need to be balanced.

* Dr. Lourie noted that the Stewart B. McKinney bill "pours" money into homelessness, but that continued advocacy is needed to increase funding and keep issues on the "front burner". Deborah Rog pointed out that there is money available for program evaluation for McKinney-funded projects.

* Dr. Lourie also emphasized that the language of the McKinney homeless legislation does not mention children, and that therefore, researchers need to make linkages between homelessness and child development more explicit.

APPENDIX E

OTHER CONTACTS

Programs Contacted

Bethlehem Day Nursery
Comprehensive Employment Opportunity Support Center
Educare Early Childhood Center
Family Resource Center
Goddard Riverside Community Center
Hartley House
Hudson Guild
Lamb's Center for Health
Nazareth Day Nursery
New York Hospital-Cornell Medical Center
    New York Children's Health Project
Plaza Head Start
Sanctuary for Families
SCAN
Urban Resource Institute

Agencies Contacted

Black Child Development Institute
Child Care, Inc.
Citizen's Committee for Children
Coalition for the Homeless
Community Food Resource Center
Legal Aid Society
National Institute of Building Sciences, Washington, DC
Save the Children
Single Parents' Resource Center

City Agencies Contacted

- Board of Education
  - Division of Curriculum and Instruction
  - Office of Early Childhood Education
  - Office of Student Progress Hotel Unit

- Department of Health
  - Bureau of Nutrition
  - Families with Special Needs
  - Lead Poisoning Control

- Human Resources Administration (HRA)
  - Agency for Child Development
  - Crisis Intervention Services
  - Health and Human Services Unit
  - Office of Policy and Program Development
  - Special Services for Children